INTERNATIONAL THEOLOGICAL SEMINARY

THE PERCEPTION OF THE ROLE OF THE HOSPITAL CHAPLAINS IN THE MULTIDISCIPLINARY TEAM IN THE CAMEROON BAPTIST CONVENTION

By

Fanny Nacha Talikong

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ABSTRACT

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Healthcare workers provide quality of care to patients who enter the hospital. However, for this care to be holistic, a chaplain should be a part of the team to oversee the spiritual components. Multidisciplinary Team (MDT) is a group of health care professionals (physicians, nurses, chaplains, and social workers) working in collaboration with the patients, and families to achieve identified outcomes. However, members of an MDT need to have an understanding on how to utilize the chaplain's multifaceted training for the best holistic care. The purpose of this phenomenological study was to review and explore, through the lived experiences of chaplains the perception of the Role of the hospital chaplains in the multidisciplinary team in the Cameroon Baptist Convention.

The study utilized a qualitative research method within the hospital context using the chaplains as the sample population and a sample size of twenty-five. The setting was within the context of the hospital using questionnaires, one-on-one interviews via zoom, WhatsApp video calls and direct voice mail calls, and observations as data collection methods. This aimed at helping create awareness, sensitization, and educative seminars to the MDT regarding the role and function of the hospital chaplain within the hospital.

Moreso, it challenged institutions, the MDT to work towards a more collaborative approach with the chaplains.

Mentor: Dr. Ross Purdy 213 words

ENGLISH LANGUAGE DISCLAIMER

As a non-native speaker of English, I am aware that my writing may at times lack clarity, though I have attempted to write as clearly as possible. Please note that the primary purpose of this work is to acknowledge a theory and to apply it to a particular context. I appreciate the editorial assistance I have received from various individuals but acknowledge that the responsibility for this work is entirely my own.

DEDICATION

To God be the glory. I dedicate this work to my husband, Dr Njapba Augustine, my mother, Rhoda Talikong, my children, Blessing, Graham, and Shalom. To Rev/Minister Nfor Wilfred Tamfu, and my siblings who have stood by me financially, morally, and spiritually.

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I appreciate my father in the lord, Rev/Dr Ndongndeh Godlove and wife who stood with me throughout this project with meaningful contributions. I appreciate my mom and my siblings for being there for me. Special thanks go to the ITS faculty staff who impacted me with knowledge. throughout this journey. It was an honor to study at ITS. May the Lord use me. I am His work in progress.

Thanks to all the chaplains in the CBCHS who contributed to this study, and special thanks to the chaplaincy team who kindly agreed to participate in the interviews and filling the questionnaires.

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CHAPTER 1

INTRODUCTION

1.1 Background to the Study: Ministry Context and Hospital Setting.

The hospital is one of the most significant places of ministry for the church today. It offers an opportunity to minister to people who are vulnerable, sick, and needing God's healing touch. At this crucial point in a patient's life, they are searching for purpose and meaning in life for wholeness to be achieved. Kirkwood says that many ministers are becoming aware of the importance of chaplaincy ministry.[1] When people go there, thoughts are lingering and hovering between hope and fear. In the hospital, there is a network of specialized tasks, hierarchical relationships, horizontal and vertical lines of communication, shared responsibilities.[2] The hospital is a restless atmosphere in which sharply timed procedures and techniques demanding scrupulous care places all those taking part at times in an almost tangible nervous tension with one another. Anne Golin, a counselor, argues that MDT provides an avenue for treatment utilizing diverse disciplines to provide the best quality care for the patient. The focus of this team is the patient who is seeking help from the different members of the team.[3]They all move into the wards for what is commonly called "Ward Rounds" comprising of all the members of the team.

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[1] Neville Kirkwood, *Pastoral Care in Hospital* (Harrisburg, New York: Morehouse publishing, 1998), ix 5.

[2] Faber Heije, *Pastoral Care in the Modern Hospital* (London: SCM press, 1971), 7-10.

[3] Ducanis Alex and Golin Anne, *The Interdisciplinary Health Care Team* (London: England, 1979), 2-9.

There is also what is called the ward report in which the charge nurse presents detailed analysis of each patient's condition accompanied by a handing over from one shift to another. Joseph' R. Jeffries comments that when then MDT come together for ward report, their activities are ranges from the nurse who present the patient's condition and records for deliberations, team members give their inputs and impressions based on the suggested plan of care from the group, a consensus is reached or agreed upon as a common plan of action as the team moves from one patient to the next for execution and care.[4] The collaboration among the team is centered around the care for the patient and the necessary actions which will help in recovery. If the chaplain in this modern hospital is going to make a fruitful contribution to these anxious people, he has to be a part of the MDT and to have more than a superficial understanding of his own position in this social structure, be highly sensitive to the psycho-spiritual conditions of those he is ministering to.[5]

Being hospitalized can bring a person's life into perspective, especially in a time of crisis. A hospital has a unique way of bringing the drama of life and death to the forefront and, at times it confronts people with the serious question about the purpose of life**.** Penelope Wilcock states that it is hard for a patient to believe in a God who cares, who is merciful, and who offers security when their life situation that was once familiar and reliable is now disintegrating, and deteriorating."[6]Neville, Kirkwood who was a hospital chaplain, lecturer, and preacher acknowledges that "a hospital ward is packed with the widest possible range of feelings and emotions."[7] As a chaplain, the researcher has witnessed some of these emotions, some of which include a need for a strong sense of

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[4] Joseph R. Jeffries, "*The Role, and Function of a Hospital Chaplain in an Interdisciplinary Team,"* (PhD diss., Liberty University School of Divinity, 2020), 15-20. ProQuest Dissertations & Theses Global.

[5] Heije, *Pastoral Care*, 8.

[6] Wilcock Penelope, *Spiritual Care of Dying and Bereaved People* (London: SPCK, 1996), p. 60-70.

[7] Kirkwood, *Pastoral Care*, 13-14.

dependence, grief, guilt, and being afraid of the outcomes. There is often a question, why is this happening? Daniel Winiger, a hospice chaplain, confirms that, during times of serious illness and end of life issues, the domain of medicine starts to overlap as they yearn for spiritual interventions. The Patient and their families begin a search for meaning in life. This quest brings them to a stage where they are open and willing to integrate medical facts with their faith. At such moments, the physicians' perceptions of the chaplain's role become particularly relevant.[8]

Chaplains offer a supportive presence that serves to remind patients and caregivers that people are more than just their medical conditions. While medical professionals focus on patients' medical conditions, chaplains seek to read the whole person thus achieving holistic care. However, the chaplain receives little attention from other health-care providers about their role which makes them underused, important as they work in the team. Stephen, Pattison, a professor in theology, who has experienced inter professional team in health care settings says that chaplains have often been presented as marginal members of the health care delivery team and are now required to negotiate their position among the Multidisciplinary Team (MDT) member or even explain their role to other members.[9]

Chapter one unveiled the problem statement and the purpose of this phenomenological study. The question was, how is the role of the chaplains perceived on the MDT? The study sought ways to answer this question as the chapters unfolded with a resume of who a chaplain is.

Christopher, swift who was a health care chaplain at Leeds Teaching Hospitals says that some MDT do not necessarily understand how to use the chaplain's

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[8] Daniel Winiger, "*Physicians' Perception of the Chaplain's Role in Critical care"* (PhD, diss., Asbury Theological Seminary, 2007), 15-16, ProQuest Dissertations & Theses Global.

[9] Pattison et al., *Emerging Values in Healthcare…*

multifaceted training for the best holistic patient care.[10] Wendy Cadge a sociologist of religion of religious studies comments that Ironically, chaplains, skilled at mediating between patients and hospital staff-often have no one they can rely on to advocate for them at budget time, no one who can "translate" the tangible benefits chaplains provide to patients, families, and staff into terms that the hospital administrators can understand.[11]Some schools of thought have stated that, in response to this dilemma, if chaplains wish to be recognized healthcare professional, they should be able to describe to themselves, and to others, what constitutes "quality" in their area of patient care. Like other health care professionals, chaplains should specify how their profession and their day-to-day work in the hospital contribute to the ongoing task of quality improvement in health care. This is no easy task. The challenge here is that the work chaplains do is difficult to measure, and this is where conflict stems from. This result has led to the MDT underusing chaplains. The research aims to look at the factors contributing to the underuse of chaplains, the poor perception of chaplain, and to narrow that gap that exists between the chaplains and the MDT.

The purpose of the research was to review and explore the perception of the role of the hospital chaplain in the MDT in the Cameroon Baptist Convention. Through the exploration, outcomes that clarified the perception role of the chaplain were obtained. The integration of chaplains into healthcare settings is positively associated with patient outcomes and satisfaction. This study was to promote and enhance collaboration amongst MDT members.

Harriet Mowat who has worked as a healthcare chaplain in the United Kingdom says that chaplains face different challenges as they work in an environment centered

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9 Christopher Swift, *Hospital Chaplaincy in The Twenty First Century: The Crisis of Spiritual Care on the NHS* (England: Ashgate, 2014), 29-35.

11 Raymond De Vries, Nancy Berlinger, and Wendy Cadge, "*Lost in Translation: The Chaplain's Role in Healthcare,"*1, no.1 (Hastings Center Report, 2008):5-15, https://www.academia.edu/23411356/.

around medicine and costs [12] Lawrence E. Holst, a member of the Pastoral Care department of the Chicago Lutheran General Hospital says that the hospital chaplain walks between two worlds: religion and medicine. Each world has its own domain, and demands, its assumptions, and mission. Each needs the support of the other. [13] These worlds are complimentary but sometimes they are in conflict. Their interaction always requires careful exploration. The chaplain has allegiance to both worlds and both worlds have an allegiance to the chaplain. [14] By training, history, and ordination, the chaplain feels a deep relationship to the church, but the chaplain's daily interactions are in the hospital, to move between these two worlds that are so markedly different-yet were at one time united. [15] The tension can be painful, confusing, exciting, creative. Christopher confirms this tensions when he observes that chaplaincy has remained at the periphery in the health care delivery. [16] Like many tensions, it is never fully re-solved and never will or should be. The tensions that chaplains experience in walking between these two worlds can be identified in four categories: (1) the context of the hospital, (2) the chaplain specialized training, (3) the strong influence of psychology in the chaplain ministry, (4) medicines and religions conflicting perspectives. [17]

Before Clinical Pastoral Education came, chaplains were religious people who visited the hospital. [18] Lawrence says that hospital chaplains begin preparation for ministry in the seminary, with a major emphasis upon Biblical theology, dogmatics, church history, philosophy, the arts, and humanities. Clinical Pastoral Education (CPE)

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[12] Harriet Mowat, *The Potential for Efficacy of Healthcare Chaplaincy and Spiritual Care Provision in the NHS* (Aberdeen, Scotland: Mowat Research, 2008), 45-50.

[13] Lawrence E. Holst, *Hospital Ministry: The Role of the Chaplain Today* (New York: Cross Road, 1985), 13-15, 20-22.

[14] Holst, *Hospital Ministry, 13.*

[15] Holst, *Hospital Ministry, 20-22.*

[16] Swift, *Healthcare Chaplaincy*, 40-45.

[17] Holst, *Hospital Ministry*, 8, 20-22.

[18] Wendy Cadge, *Paging God: Religion in the Halls of Medicine* (Chicago: University of Chicago Press, 2012), 20-25.

was an effort to get theological students out of their classrooms and chapels into the wards and clinics that house suffering people. It helped integrated theological and psychological patterns so that the chaplain could offer care effectively. CPE causes the chaplain to gain self-awareness and self-evaluation as he ministers.[19]

1.3 Problem Statement

The role of the chaplain in the MDT remains widely misunderstood, undervalued, and underused. This is evidenced from the lived experiences of chaplains who have worked in hospitals. However, factors contributing to the challenges were unclear.

1.4 Purpose Statement

The purpose of the research study was to explore, and review the extent to which the MDT perceived, underused, and devalued the chaplain's role on the team. Identification of the factors that led to these experiences were investigated. The factors that clarified these perceptions were also developed. Therefore, the study was aimed at bridging the gap between the chaplains and the MDT through awareness, educative seminars, and team dynamics.

1.5 Central Research Question

How does the MDT perceive the role of chaplains and their integration in the MDT?

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[19] Howard Clinebell, *Basic Types of Pastoral Care and Counseling: Resources for the Ministry of Healing and Growth* (Nashville, Tennessee: Abingdon, 1984), 42-44.

1.6 Research Questions

The following four research questions guided this investigation about the experiences and the perceptions of hospital chaplains in the multidisciplinary team.

1. How do MDT members perceive chaplains on the team?

2.vHow does this poor perception affect their physical and psychological well-being?

3. How could the poor perception of chaplains be handled so that their role could be felt in the team?

4.What are some factors that are contributing or limiting their role in the multidisciplinary team?

1.7 Importance of the Research

The study contributed to the field of theology in the sphere of pastoral care and counselling. To create a true patient-centered culture, multidisciplinary team (MDT) needed to promote team dynamics through collaboration, communication, and clear purpose. This study examined and identified factors associated with the inclusion of chaplains in the MDT.

From this study, recommendations were made to help minimize the gap that existed between the MDT and the hospital chaplains. The study showed that awareness through in-service seminars could help bridge the gap.

1.8 Limitation

This study had certain limitations which included following:

i) Time constraint. Given the vast material that was present in the chaplaincy field, and having known that an in-depth study is needed, the researcher knew that time

constraint was a struggle. To overcome this, intentionality to double the efforts put into to the study was worked upon.

ii) Some participants feared being implicated negatively by the administration if inappropriate disclosures were made. To overcome this, respondents were assured that all information was going to be kept confidential and not be used against them.

iii) The Problems of inaccuracy could exist if the sample size were too narrowed. To overcome this, the sample size was selected in a way that gave the researcher an insight into the lived experiences.

CHAPTER 2

LITERATURE REVIEW

2 1 Introduction

Hospital chaplains are specially trained to deliver spiritual care. However, factors hindering the delivery of this care in the MDT are unclear. The purpose of this phenomenological study was to be explore and review the perception of the role of the hospital chaplains in the MDT in the Cameroon Baptist Convention. The qualitative study for this research used the phenomenological method. This method enabled the lived experiences of the chaplains to be captured while drawing data from secondary sources to compare and confirm the emerging themes, findings, and to extract the required information and to analyze the findings.

The second chapter of the research study provided both the literature review and the theoretical framework for the study as well as an extensive synthesis of the current literature regarding the topics relating to the perception of the chaplain on MDT in the hospital context.

Firstly, the study discussed the chaplaincy ministry in the hospital context and its literature reviewed, expounded, and unpacked under the terms, hospital chaplain, spiritual care, spiritual care, the value of the chaplain, the role of chaplains, advocacy, ministry of presence, teams, and team dynamics.

Secondly, the literature reviewed also unveiled some factors that contributed to this poor perception about the chaplains in the MDT and its implication. A detailed

description of the literature search process, and databases was provided in this research study.

Thirdly, from the current literature, significant themes were summarized and explained, along with a plan to address the perceived gap in literature and how this study fits into the existing body of literature.

Fourthly, MDT term dynamics were proposed which could be beneficial to the health care team so that quality care through holistic approach be achieved. The literature also discussed the gaps identified and the need for sensitizing members of the MDT to understand the chaplains' role, so that quality and holistic care to patients is achieved.

Some scholarly works on the role of the chaplain in the hospital have been published. This is evident by the different articles produced by some professional chaplains through their lived experiences. However, few research studies have been undertaken to explore and review the poor perception of chaplains and how they are underused, undervalued in the MDT thus depraving patients of holistic care. Therefore, this study was aimed to fill the knowledge gap, and to ensure that the phenomenon of chaplains' role and the poor perception were clarified, understood thereby erasing misconception thus fostering and nurturing an MDT with a holistic approach which leads to quality care to all.

2.1 The Origin or Historical Foundations for Chaplaincy Ministry

Swift says that chaplains have been the subject of little historical study. An absence of this history has led to the crisis of contemporary chaplaincy, emphasizing the lack of a clear sense of identity.[20]

[20] Swift, *Hospital Chaplaincy*, 9-10.

The word chaplain comes from the early history of the Christian church. Chaplain, originally was a priest or minister who had charge of a chapel, now refers to as an ordained member of the clergy who is assigned to a special ministry. The story of chaplaincy began at the gate to the city of Amiens in 337 CE. Martin, a young soldier in the Roman army, was walking into the city during a bitterly cold winter.[21] As the crowds hurried to pass, a half-naked beggar who was close to death by sitting nearby. Martin, unpaid and having only his military uniform, stopped, and looked at the man who gazed back at him expectantly, and then he stretched out to him. After a slight hesitation, Martin took out his sword and then removed his cloak and sliced it through the middle giving one half to the man and using the other half to cover himself. Later that night Martin had a dream, he saw a vision of Christ himself wearing the cloak he gave to the beggar saying, "look at the cloak that Martin gave me today."[22] The dream affected Martin that he tried to leave the army and in 339 CE he was released into civilian life. From there he went on to work for the poor and increase awareness of the presence of God in ordinary people. He created several communities and became a church leader.

His cloak, or half a cloak, became a precious object in military and royal circles. It became a spiritual symbol for the whole community. The cloak was used in the taking of oaths and was carried into battle and came to symbolize all that was best in humanity, a symbol of the spiritual dignity of each person and a powerful reminder of the need to seek God in ordinary things. The cloak was called a "**cappella – a cape**" It was kept in a tent or in a building that came to be called a cappella, or chapel. The person assigned to look after this sacred relic was called the "**capellano or chaplain."** The chaplain would control access to the sacred symbol and organize prayers and ceremonies for the

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[21] Jane Dave, The *Origins of Chaplaincy: Chaplain Emergent* (CEMA), Washington, April,2019, https://chaplainemergency.org.

[22] Robert Crick, *Outside the Gates: Theology, History and Practice of Chaplaincy Ministries. Higher Life* (Oviedo, FL: Higher Life, 2012), 70-80.

community to celebrate the spirituality it signified. These were the first people to be called chaplains. They began firstly in the army, then in royal courts, later in hospitals and more recently in education. Dave, Jane says that his life highlights some key features of chaplaincy ministry:

It was inspired by an act of listening and serving the needy.

He showed compassion and care.

It is based around the God-given dignity of each person in the community.

It is a form of service that challenges others to think about their own lives.

It is a ministry rooted in prayer and reflection on Jesus and the Gospels.[23]

In the mid-1920s, the new form of theological education known as CPE emerged. Rev. Anton T. Boisen, a former mental patient, was employed to become the hospital chaplain. Anton Boisen had been hospitalized for psychotic breaks from 1920 to 1922, and during his hospitalization, he felt a calling to "break down the dividing wall between religion and medicine."[24]

Those who enter the profession of hospital chaplaincy go through a formal training called Clinical Pastoral Education (CPE).[25] Boisen was a leading figure in hospital chaplaincy and a pioneer founder of the CPE movement. Boisen was the first clergy to supervise students in CPE.[26] He strongly believed in the study of human experience and prioritized having connections with real people in addition to theological education. In the summer of 1925, he offered the very first unit of clinical pastoral training, influenced by Dr. Richard Cabot, M.D., who was known as a pioneer in defining the physician's role in human well-being. Esquive comments that Boisen's life gives

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[23] Dave, "The Origins of Chaplaincy."

[24] *Association for Clinical Pastoral Education, Brief History,* (ACPE), Atlanta, GA, Januarry,15,2028, Inc. https://acpe.edu.

[25] Christina Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality into Patient Care* (West Conshohocken, PA: Templeton, 2010), 61-65.

[26] *ACPE Association for Clinical Pastoral Education*, Januarry,15,2023.

insight into his experience as a patient himself, reflects understanding of the needs of other patients, and provides theological perspectives in chaplaincy work. His ministry and life experiences paved the way for chaplaincy in the healthcare field.[27]

Joanna, Rachel Bryant in her theses has said that understanding chaplaincy in recent decades has been complicated by broader sociopolitical changes which raise significant questions about the relevance, efficacy, and distinctive contribution of chaplaincy, contributing to a "identity crisis" among chaplains.[28]When hospitals were first created, they were usually an extension of a religious group or denomination who provided care for their own followers.[29] Joanna, Rachel clarifies that when hospital chaplaincy started, most chaplains came from local churches, and the patients in these hospitals were most often strangers to chaplains.[30]For the chaplains, it was not the denomination which was essential, but the patient who was provided spiritual care during their stay.[31] The same is true today where chaplains care for patients in the hospitals regardless of their ethnicity or denomination but considered a part of their flock. Chaplains provide spiritual care to patients of all denominations who may or may not have a church family or affiliation.

2.2 Hospital Chaplains

The spiritual care association in a chaplaincy network defines a professional chaplain as a clergy who provides spiritual and religious care to individuals in hospitals, in the military, in prisons and in other organizational or institutional settings. The

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[27] Lizbeth B. Esquivel, "Application of Clinical Ethics Consultation to the Hospital Chaplain's Role" (master's Thesis., Wake Forest University May 2023), 3-4.

[28] Rachel Bryant Joanna, "*Assertion and Assumption*: *A Single Site study of Acute Healthcare Chaplaincy"* (master's Thesis, University of Birmingham September 2013), 8-10.

[29] Harold G. Koenig, *Medicine, Religion and* Health (West Conshohocken, Pa.: Templeton Press, 2004), 160-165.

[31] Joanna Rachel Bryant. "*Assertion and Assumption*: *A Single Site study of Acute Healthcare Chaplaincy,"* (master's thesis, University of Birmingham September 2013), 21-22.

chaplain is also the spiritual leader of the institution.[32] Robert Crick who has served as director of the church of God chaplains Commission comments that a chaplain can work in the context of any institution presenting God who wants to see us whole.[33] Naomi, K. Paget a board-certified chaplain describes chaplains as clergy from faith-based denomination who have chosen to minister to a group of people outside the walls of a church. They are usually employed by an institution or agency and serve the clients, families, and employees of the institution.[34] Lucy, Bregman confirms that the chaplain ministers in the institution whether it be through prayer, devotions, and counseling. A hospital chaplain is the patient's advocate, counselor, shepherd who leads in meditation, worship services or funerals, and memorial services.[35] The chaplain is also the spiritual leader of the institution.[36] George Handzo states that there is within everyone the ability to try and find purpose and meaning to life and a chaplain is there to journey with them.[37] Kelly states in his chaplain research that, healthcare chaplains work on the premise that all who inhabit healthcare communities as patients, care givers, staff and volunteers have a spiritual component to their makeup, as indeed does the organization which they are cared for or work in and are part of."[38] I agree with Kelly as anyone in a problem seeks solution. For chaplains, it was not about religious affiliation, which was essential, but the patient who was provided spiritual care during their stay.[39] Chaplains provide spiritual care to patients of all religious affiliations who may or may not have a church or

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[32] *The Spiritual Care Association*, https://acpe.edu/ Atlanta, Georgia, January,2020.

[33] Robert Crick, *Outside the Gates*: *Theology, History, and Practice of Chaplaincy Ministries* (Higher Life Publishing, 2012).

[34] Naomi K. Paget and Janet McCormac, *The work of the Chaplain* (Valley Forge: Judson Press, 2006), 2-7.

[35] Lucy Bregman, *Religion, Death, and Dying* (Santa Barbara: ABC-CLIO, 2009), 4-6.

[36] *The Spiritual Care Association*, March 2020, https://spiritualcareassociation.org/literature.

[37] George Handzo, Chaplaincy: *A Continuum of Caring*: Oncology (Williston Park, 1996),45-47.

[38] Kelly Ewan, *The Development of Healthcare Chaplaincy, The Expository Times*, no.10 (July 2012), 470-475. https:// www.proquest.com.

[39] Ewan, *The Development of Healthcare Chaplaincy,* 473.

affiliation at all says Kelly Ewane. William Purdy lauds this idea by affirming that chaplains listen to the patient and talk with them about meaning, hell, heaven, God's existence, and the meaning of being human and living a limited life.[40]

Before becoming a chaplain, some pastors had served in local congregations prior to their service in a medical center. Most chaplains are either commissioned or ordained and they maintain ongoing accountability to a faith community and an ecclesiastical authority.[41] They remain true to their religious traditions, making sure that their pastoral identity is not lost. A typical day with the chaplain can be anything from psychological, physical to spiritual, with challenges to adjust to the patient's spiritual and religious differences.[42] Since the chaplain deals with such a vast array of issues, it could account for many of the hospital staff not fully comprehending the chaplain's capabilities within the context of the hospital.

Chaplains make tangible impact upon interacting with patients and families in the hospital by instilling hope.[43] This simple act of sharing, encouraging and instilling hope holds immense powers of healing. Also, chaplains have a prophetic voice because they have a responsibility to speak truth and justice to any form of injustices within the given institution, they find themselves in. Lastly, they are priest and so their identity should carry priestly qualities. They enter the ministry situation with no personal agenda and the attitude of a servant. Chaplains are an extension of Christ's ministry to all the vulnerable and the sick.

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[40] William A Purdy, *" Spiritual Discernment in Palliative Care*," 5, no. 1 (July 2004): 139-146. doi.org/10.1089/10966210252785105.

[41] Larry Vandecreek, *Health Care Chaplains, and Community Clergy:* Navigating the Maze Professional Relationships (Haworth Press, NY,2002), 27.

[42] Vandecreek, *Health Care Chaplains*, 30-35.

[43] Pew. U. S, Religious landscape Survey (Pew Research Center,2008), February,2020, http://religions.pewforum.org/pdf/report-religious-landscape-study-full.pd.

Bryant comments that a consistent thread in literature is the poor perception, and the recognition of chaplains.[44] This has made them to be devalued, and underused.[45]Joanna continuous that the word chaplain is not recognized as a profession to many staff because everyone who visits the hospital to pray with patients, be it pastor or laity feel entitled to using chaplain thus creating confusion between the chaplains that are trained and the pastors who are not.[46] A statement goes that all chaplains are pastors but not all pastors are chaplains.

Wendy states that confusion around the chaplain, and assessment protocol have made the health care team hesitant to value the trained chaplain.[47] Moreso, the chaplain has the credentials but no license to practice. Furthermore, the poor perception of chaplains stems from what Wendy calls soft skills. He explains that the work of medicine is often divided into curing and caring, with the "hard "skills of curing or controlling disease, which is given more attention and respect is over the "soft" skills of caring or "healing in which chaplains are placed in this soft skill.[48] From this argument, this will only keep the chaplain at an auxiliary position and will cause the chaplain to be disrespected. Furthermore, in a hospital, nurses are a large profession that is often unionized and whose services are in high demand, but chaplains are a small profession that lacks the collective power to protect their autonomy at the negotiating table.[49] From the above-mentioned points, one might explain that the poor perception about their role can cause their role to be devalued and underused.

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[44] James Welford Woodward, "*A Study of the Role of the Acute Healthcare Chaplain in England*," (PhD thesis, Open University, Birmingham,1998), 20-25, https://oro.open.ac.uk/57940/1/57940.

[45] Joanna *Bryant. "Assertion And Assumption: A Single Site Study of Acute Healthcare Chaplaincy"(PhD diss.,* University of Birmingham September,2013),7-10, ProQuest Dissertations & Theses Global.

[46] Bryant, "*Assertion and Assumption,"* 14

[47] Cadge, *Paging God*, 25.

[48] Cadge, *Paging God*, 26.

[49] Cadge, *Paging God*, 27.

Christopher Swift affirms that the way chaplains are treated can lead to a logical conclusion that they are devalued. Swift drew illustration from the fact that, in one of the hospitals, a decision was made to cut off chaplains and after facing criticism from the public, the decision was reversed.[50] The experience highlighted more general problems in the way chaplains were regarded. The pay proposals for the chaplains were placed alongside cleaning staff and hospital secretaries in some hospitals.[51] This placement revealed how chaplains were regarded and ignored in the hospital.

Swift insists that chaplaincy has always been a peripheral aspect of health services provision, and the crisis of identity. Swift reiterates that a lack of awareness of the chaplain's role, and the typical association of a chaplain's arrival with impending sad news or a death, results in a chronic underutilization of chaplains. Lawrence says that from the look of things, chaplains might not have a chance to minister in the hospital in the future because the hospital budget will not factor chaplains into their finances.[52] Woodward in his thesis substantiates this point more by saying that, instead of shying away from hospital chaplains based on inaccurate preconceived notions, it is time to think of chaplains as friendly and indispensable allies in the hospital. Woodward authenticate this perception by emphasizing that confidence in theology as an appropriate and coherent knowledge base for chaplaincy has decreased.[53] According to Woodward, chaplains are more interested in evidence base practice than the Bible that is truth in all matters of faith and practice. Bryant noted that Anglican chaplains felt that they did not have support from the Church. Amid an inevitable host of negative emotions generated by the hospital, there exists great power in the simple act of human connection with a chaplain. Such a connection and overt acknowledgment of a patient's humanity rather

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[50] Swift, *Hospital chaplaincy*, 25.

[51] Swift, *Hospital Chaplaincy*, 30.

[52] Holst, *The Role of the Chaplain*, 234-236.

[53] Woodward J, "*A Study of the Role of the Acute Healthcare Chaplain in England"* (PhD diss., Open University, 1998), 100-110.

than a medical condition can be far too easily trivialized or dismissed by medical staff who are exhaustively confronting problems of a deeply corporeal nature.

Holst highlights medicines and Religion's conflicting perspectives on suffering and emphasizes that the chaplain's role is not to explain, cure, or eliminate disease. Rather, the chaplain seeks to engage the sufferer while harboring no illusions about the banishment of suffering.

Interestingly, the chaplain identifies with both worlds; yet does not feel entirely at home in either. What an irony for chaplains. Holst expands that chaplains are an enigma to both worlds: medicine does not consider them medical enough and questions their relevance while the church often does not consider them pastoral enough and questions their identity. But the fact is that despite the tensions and enigmas, the hospital chaplain is very much committed to both worlds and is a vital link between them.[54]

2.4 Misconception of the Chaplain's Role.

Caroline Yih a researcher of Christian spirituality in the hospital has compiled some points about the misconception of hospital chaplains. She echoes that the misconception of the chaplains' role places chaplains in a precarious position in the healthcare context and this has damaging effects beyond preventing their full integration with the other elements of the holistic MDT at work.[55] Yih says that due to the poor understanding of their role and the associated lack of value placed on their work, they are more vulnerable to marginalizing treatment at work, which ultimately impacts their experience of grief.[56] Chaplains are called on to practice in a secular and pluralistic

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[54] Holst, *Hospital chaplain*, 12,25-26.

[55] Caroline Yih, "The Chaplain Grieves in Silence: Marginalization, Disenfranchisement, Grief, and Chaplaincy," 1, no.1(2021): 1-10, https://www.academia.edu/52115344.

[56] Yih, *The Chaplain Grieves in Silence*, 1-2.

hospital setting which is frequently experienced to be acutely alienating from their role and the church.

The role of chaplains in MDT is not usually as well understood as the roles of the other team members. Their role is perceived as ambiguous, which reflects where the dimension of spiritual care is placed within the holistic vision of healthcare provision. The ambiguity of the chaplain's role in the secular and pluralistic healthcare setting leads to the perception of their relevance as second rate by the other MDT members. This is captured by the following points.

1) Chaplains are acutely aware of the reality that they are called to practice in a world that belongs to others and their work is always to some extent peripheral to medical effort. The chaplains practice in the hospital settings which frequently compels them to bear up and to adapt to the suffocating constrictiveness imposed by the institutions keeping them as outsiders to the flow of power. Winiger, a hospice chaplain, observed in his thesis that it is not uncommon for different disciplines to have difficulty collaborating with one another. Daniel explains that Part of the problem may arise because of stereotyping of one discipline by another in terms of beliefs about skills, abilities, and responsibilities.[57]

Daniels details that teamwork is essential if hospitals seek to provide holistic care for their patients as mentioned earlier.[58] Larry Vandecreek a Methodist Hospital chaplain of Indianapolis validates that strengthening the chaplain-physician relationship faces fundamental problems. Chaplains and physicians have often been hesitant toward each other.[59] Many chaplains project their unfinished authority-power conflicts onto physician colleagues. Conversely, physicians project their mixed feelings concerning religious and

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[57] Winiger, "Physicians' Perception of the Chaplain's Role," 56-60.
[58] Winiger, "Physicians' Perception of the Chaplain's Role," 58.
[59] Holst, *The role of the Chaplain*, 12-15.

spiritual issues onto the chaplain.[60] These mutual projections naturally lead to confusion, ambivalence, hostility, or distance. Vandecreek states that the processes are usually unconscious, beyond the individual ability to change them at will.

2). The strained collegial dynamics that chaplains encounter in the MDT makes them feel devalued alongside the hierarchical nature of the medical milieu and some associated forms of intimidation. This has brought untold pain and grief to chaplains. When chaplains are constantly exposed to and plunge into the alienating and disempowering professional environment, it will provoke in them a deep sentiment of vulnerability.[61] They are left with a social pain- the perception that one is being excluded from desired relationships or being devalued by desired relationship partners. In their vulnerable state, the fear of further detachment and loss of support makes chaplains more susceptible to disenfranchised grief.

3). Furthermore, Yih propounds that chaplains live in a constant tension between adapting to their marginalizing conditions and striving to retain the essential values of their role.[62] But in this tension, some aspects of those essential values are also lost. Holst states that chaplains are caught between two worlds. The world of medicine and that of religion and sometimes they are in conflict.[63] The tension can be painful, confusing, and like many conflicts it is never fully resolved and perhaps never will be resolved.[64]

4). Another factor that can lead to being devalue, and marginalized is the organizational imbalance of power, personal oppression, lack of empowerment and a professionally uncooperative culture which makes them to be vulnerable and experience of interpersonal

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[60] Larry Vandecreek and A. Burton, The Chaplain -Physician Relationship (NY: Howard press,199), 57-58.

[61] Yih, *The Chaplain Grieves in Silence*, 7

[62] Yih, The *Chaplain Grieves in Silence*, 5.

[63] Holst. *Hospital Ministry*, 12

[64] Holst, *Hospital Ministry,11*-15.

violence. Once a chaplain, growth as an active employee in slow such that most chaplains will prefer to go back to churches.[65]

5). Finally, disgusting treatments of chaplains include expressions of hostility regarding the presence of a chaplain in the wards and denying them access to medical charts or even a chair to sit in when visiting patients.[66] This is sad because this is an indication that they are not part of the team. In the CBC, chaplains have access to the charts as they move into the wards or units.

2.5 The Value of the Hospital Chaplains

Vandecreek states that chaplains are valuable in providing hope to patients. Not only are chaplains available to health care staff for the regular services of pastoral care, but they are also able to provide extra service to their co-workers, including nurses and clergy, in the promotion of spiritual care and values. After a particular stressful event, chaplains may provide formal or informal critical incident stress debriefing sessions for those involved. Chaplains are often involved in referring employees who are in need to the appropriate resources within the institution (e.g., an employee assistance program, financial crisis funds, emergency leave) or in the community (e.g., family counseling, social service agencies).[67]

Their regular assistance in stress management and in validating and encouraging individuals is particularly important in the strained and stressful workplace that is becoming more and more the norm in health care.[68] David Switzer, commented that the value of chaplains comes from the fact that chaplains are for patients, families, and staff. Also, the chaplains promote wellbeing. They helped staff initiate conversations and

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65 Vandecreek, *The Chaplain -Physician Relationship*, 55-60.

66 Yih*, The chaplain grieves in silence*, 7

67 Vandecreek, *The Chaplain -Physician Relationship*, 57.

68 Vandecreek, *The Chaplain -Physician Relationship*, 27,29.

sought guidance about spiritual matters. They have been bearers of goodness, release stress and celebrate birth and birthdays.[69]

Harold Koenig, a psychiatrist in the university says that when patients find themselves questioning the very foundations of life like, what gives hope and meaning to their lives? Who makes up their support network? What makes Their life worth living? The chaplain is there with the patient validating the presence of God. As the art of health care chaplaincy is deeply rooted in communication, chaplains are professionally trained to engage in conversations that allow patients to grapple with these sorts of questions.[70]

Physicians, nurses, and all MDT refer patients with spiritual needs to hospital chaplains at a minimal level. However, the role of the chaplain has diminished in some hospital because they are 'poorly understood.[71]

Dawn says that hospital care teams often underutilize chaplains. He continues that part of this underuse may also be because of a chaplain's limited self-understanding and assertiveness on the healthcare team. This is important because the chaplain needs to know who he is and what he represents. Another factor may be staff misconceptions of the professional training and expertise that present-day chaplaincy requires.[72] Cadge sates that in carrying spiritual assessment, some hospitals that faced constricted health care budgets chose to redundant chaplains first because their role was not valued.[73] Jeffries suggested that may be the redundancy of chaplains could have been because their work could not be measured as those of nurses.[74] More so, he lamented that compounding poor perception and preconceptions concerning the chaplains, a lack of awareness of the

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69 David Switzer, *The Minister as Crisis Counselor (*Nashville: Abingdon,1974),15-17.

70 Harold" Koenig, *Religion, spirituality, and health: the research and clinical implications*," (2012):278-279. Doi: 10.5402/2012/278730.

71 Swift, *Hospital Chaplaincy*, 82.

72 Leah Dawn and Daniel Schipani, Spiritual *Care giving in the Hospital: Windows to chaplaincy Ministry* (Ontario: Pandora Press, 2006), 44-50.

73 Wendy Cadge, W. Bandini. "*The Evolution of Spiritual Assessment Tools in Healthcare*,"52, no. 5 (October,2015), http/dx.doi.org/10.1007/s12115-015-9926, 430-437.

74 Jeffries, "*The Role and Function of a Hospital Chaplain*," 45-46.

chaplain's role, and the typical association of a chaplain's arrival with impending unwelcome news of death, resulted in a chronic underutilization and devaluing of chaplains.

Swinton, Joseph a Professor in Practical Theology and Pastoral Care carried out a study amongst healthcare chaplains in which they sought to establish the relevance of Christian chaplaincy, the basis for the profession of chaplaincy in the light of the call for generic spiritual care and the issue of the integrity of the Christian chaplain within the emerging understanding of spirituality.[75]Despite the plethora of evidence that spirituality is critical to health and wellbeing in health care settings, the chaplain who provides this care is not viewed as an integral part of the health care team but as an "ancillary consultant", and chaplains continue to be relegated in many health care institutions. The chaplain is there for psycho spiritual and psycho emotional support and if the chaplain is in crisis, then there is this logical conclusion than they are not valued.

Swift suggests that both the chaplains and academic researchers have noted the need to clarify what chaplains do, to communicate the contribution of their spiritual care to health care teams. When their role is known and accepted, it will be respected, and valued.[76] There is a saying that when the value of a thing is not known, abuse is inevitable, and this applies to the case of the hospital chaplain.

2.6 Hospital Chaplains and Global Pandemic

Swift comments that despite growing evidence for the impact of chaplains, they are commonly undervalued and misunderstood by their organizations, and the global pandemic revealed the consequences of this confusion. Chaplains experienced considerable disruption to their usual practice, with enforced social distancing having the

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[75] Swinton J. "*A Question of Identity: What does it Mean for Chaplains to Become Health Professionals*?" 8, no.1 (Ocober,2020):6-30. DOI: 10.1558/hscc.39783

[76] Swift, *Hospital Chaplaincy*, 1.

biggest impact. Out of necessity they embraced technology to maintain contact with patients and families and shifted the focus of their support to staff. [77]Austyn Snowden a lead researcher, in the European Research Institute for chaplains in Healthcare said while some chaplains were applauded as heroes along with their fellow health colleagues, others were seen doing nothing, still, some were blamed for having abandoned their staff and some chaplains felt ignored and neglected.[78] Snowden continued his argument that even though many organizations understood what chaplains did, chaplains themselves were neither clear or unclear about their role during and post pandemic. Chaplains who participated felt their role was neither clear nor and, they also did not understand each other during the pandemic. A chaplain who had been a CPE educator commented that he held space for the staff and acknowledged their suffering. He also played a role as a surrogate family member for patients and families since families were not able to visit loved ones even at the end of life. He commented that was overall exhaustion because of wearing so many N95 masks and not knowing the proper protocol at the beginning. The COVID 19 left few of us unaffected but all health care workers have been borne the brunt of impact.[79]

Csaba, Szilagyi a director of Spiritual Care at Johns Hopkin university in his qualitative findings reflected diverging themes in chaplains' experiences such as being seen as unimportant, optional, and being professionally isolated, compared to those who were viewed as essential, well-integrated, and valued in their healthcare institutions'COVID-19 response.[80] With these conflicting views by chaplains, there was no way they could be successful as a say goes that a team that is divided cannot win.

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[77] Swift, Hospital Chaplaincy, 70-80.

[78] Austyn, Snowden, "*What Did Chaplains Do During the Covid Pandemic? An International Survey*," 75, no. 1 (March17,2021), doi.org/10.1177/1542305021992039.

[79] Mandy Mizelle, *Prayers, and Blessings for Healthcare Workers* (New York: Morehouse Publishing, 2021), i-10.

[80] Csaba Szilagyi et al., Chaplain Leadership During COVID-19...

Szilagyi says that the importance of spirituality in improving health outcomes has also been demonstrated in patients during the COVID-19 pandemic. Some chaplains in the Cameroon Baptist Convention Hospital commented that, some patients the chaplain spoke to, encouraged developed coping strategies, and stayed hopeful than the patients that the chaplains did not see. Lindsay B. Carey who has an interest in palliative and end-of-life care agrees that the value of the chaplain during and after the pandemic raised an awareness of the need and requirement for pastoral and spiritual support for patients in hospital settings.[81] This season sounded like a blessing in disguise to the chaplains because their role was showcase. COVID-19 has also reminded the population of the importance of rituals and chaplaincy services. Gusman confirmed that healthcare chaplains witnessed an increased demand on their services.[82] He also noted however that to some chaplains, access was denied during this time and the weight of spiritual needs of the patient fell on the nurse who had little or no training on handling spiritual needs.[83] Support from healthcare chaplaincy services is known to have been beneficial effects in terms of assisting patients to navigate important life journeys in the hospital setting and improving their perception.[84]The creativity and proactive steps taken by chaplains to see that they meet the needs of the patients in their homes through the use of technology was applauded. Through phone calls and video calls, chaplains offered prayers, and instilled hope.

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[81] Carey et al., COVID-*19, Mental Health, and cancer*…

[82] Alessandro Gusman, *Providing Spiritual Care to In-Hospital Patients DuringCOVID-19: A Preliminary European Fact-Finding Study*, Journal of Religion and Health, Journal of Religion and Health 61, (2022): 2214–2218, doi.org/10.1007/s10943-022-01553. 2018-2024.

[83] Gusman, "P*roviding Spiritual Care to In-Hospital*," 2223-2225.

2.7 Role of the Hospital Chaplains

Holst states that chaplains help patients through words, acts, and relationships to experience the reality of God's presence and love in their lives.[85] Chike, Nzegwu in his thesis states that chaplains are pastoral practitioners who seek to build a relationship of trust through compassionate presence and thereby offer help and support to a diversity of people. Chaplains offer a comforting presence in times of distress, for patients, families, and hospital staff. They provide various support services to patients, families, and the staff of their respective health organizations.[86] Koenig numerates their activities within the hospital ranging from crisis intervention, emotional enabling, ethical consultation, deliberation, life review, patient advocacy, counseling bereavement, and empathetic listening.[87]With regards to empathetic listening, some chaplains have commented that pastoral interventions assumes a caring presence, a compassionate heart and a continued active listening and should not be put as a role of the chaplain since it cuts across all theirs activities. But some still maintain that it is a role on its own. Paul, Bramadat a director at the center for studies in religion in Canada comments that chaplains describe their services as those that bring wholeness, and healing which help patients to cope.[88] Paul confirms this by indicating that chaplains offer support and some therapeutic interventions that bring satisfaction to the patient.[89] Leah Dawn and Daniel and Jeffrey

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[85] Holst, *Hospital Chaplain*, 46-7.

[86] Chike Nzegwu. "*Chaplaincy Inclusion in Hospital Interdisciplinary Teams and Its Impact on Chaplains' Well-Being*, Walden University" (PhD, diss., November 2018), 34-40.

[87] George Handzo and Harold Koenig, "*Spiritual Care: Whose Job is it Anyway," 97, no.12, (March 2004):11170-1190*. https://www.acperesearch.net/Winter.

[88] Bramadat, Coward , and Stajduhar, *Spirituality in Hospice Palliative Care.*

[89] Bramadat, Coward , and Stajduhar, *Spirituality in Hospice Palliative Care,27,36.*

Hayman, attest to the fact the chaplains respond along with other medical professionals to trauma healing[90]

2.8 Categorization of the Role of the Chaplains

2.8.1 Assessments

Chike mentions that the chaplain is responsible for the spiritual health of the patient, which is analyzed by a spiritual assessment tool.[91] The chaplain assesses spiritual distress, provides support and counseling to the patient and family, leads, or promotes supporting rituals, as appropriate, and promotes linkages to the community.

2.8.2 Debriefing

Granger, Westberg states in his book that the chaplain ministers to MDT colleagues like social workers, physicians, nurses in debriefing their stressful moments with them after a difficult procedure or a critical incident by spending time with them in group sessions.[92] Chaplains are often used to debrief staff members following a patient's death and help reflect on the experience, which is often beneficial to the team.

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[90] Jeffrey D. Hayman, "*Understanding the 21st Century Practical Implications of Chaplaincy Ministry in the City of Milwaukee*" (PhD diss., WI Liberty University John W. Rawlings School of Divinity December 2022), 56.

[91] Nzegwu, "*Chaplaincy Inclusion in Hospital Interdisciplinary Teams*," 36

[92] Granger Westberg, *Minister, and Doctor* (New York: Harper and Brothers,1961), p, 67-69.

2.8.3 Training

Professionally, the hospital chaplain receives specific training for interventions like suicidal cases, depression, and mental cases. This has given him a name among the clergy, as the "hospitalist."[93]

As a doctor is to the sick, so is the chaplain to the hopeless, those who have lost meaning in life. The chaplain journeys with the patients to instill hope as they search for meaning and purpose in their lives. Koenig maintains his view that the general practitioner focuses on the physical symptoms while the chaplains take care of the psychospiritual factors. If there are signs that the patient is dealing with issues of hopelessness or loss of meaning in life, the physician should make a referral to the chaplain.[94]The MDT also benefits spiritual caregiving by contributing their perceptions about meaning, hope, suffering, or other spiritual issues related to the patient's illness.

Holst, who has been the chairperson of the division of pastoral care at Lutheran General hospital Illinois gave this caution to hospital chaplains about their function in the hospital in his book titled, Hospital Ministry: the role of the Hospital Chaplain. He states that some chaplains today function as group therapy leaders, alcoholism counselors, crisis interveners, marriage therapists, program coordinators, psychotherapists. Robert Anderson, a professor in Old Testament confirms that the role of the chaplain is seen as complicated, especially working with not only medical staff but patients as well as families.[95] These functions are being performed by other professionals like, social workers, psychologists, nurses, psychiatrists, physicians.[96] In performing such common functions, these professionals dip into a common pool of knowledge, theories, and methods but they should make sure their pastoral identity is maintained. On the surface

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[93] Dawn and Schipani. *Spiritual Care in the Hospital*,38-39.

[94] George, Handzo, and Harold Koenig, "*Spiritual Care, Whose Job is it Anywhere*?" Sothern medical Journal 9, no. 12 (December,2004):1240- 1243. DOI: 10.1097/01.SMJ.0000146490. 49723.AE

[95] Robert Anderson, *Ministry in the Spiritual and Cultural Diversity of Health Care: Increasing the Competency of Chaplains* (Independence: Routledge, 2004), 25-30.

[96] Holst, *Hospital Ministry*, 46-7.

there may be little to differentiate these professionals in the performance of these shared functions.[97] The chaplain should blend the functions in such a way that his pastoral identity is still noticed.[98]

I agree with Lawrence because some chaplains with additional skills in trying to function in some other offices have minimized their pastoral role which makes them an integral part of the healing ministry. Holst goes on to say that there are both benefits and dangers to multifunctioning. Koenig states that the chaplain should have an understanding of the psychological, psychospiritual, and social consequences of illness to make him balance.[99] Holst comments that when the chaplains do not balance their role, the tendency is that they will neglect their pastoral roles thus making it difficult to bring a distinction between the chaplains and the other health care workers.[100] In order to be balanced in one's pastoral care it is important that the chaplain factor in those benefits and dangers. The chaplain is a team member with training and expertise in meeting spiritual needs.

2.8.4 Religious beliefs

Howard, Clinebell who was a professor in pastoral counselling gives the role, and activities of a healthcare chaplains which falls in line with what other authors like Holst, Koenig, and Hanzo have projected in their books as the roles of chaplains in hospitals.[101] When religious beliefs and practices are interwoven with cultural contexts, chaplains

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97 Holst, *Hospital Ministry*, 46 -47.

98 Holst, *Hospital Ministry*, 48.

99 Harold Koenig, *Spirituality in Patient Care: Why, How, When, and What (West* Conshohocken: Templeton Press, 2007),125-130.

100 Holst, Hospital Ministry: *The Role of the Chaplain*, 47-50.

101 Howard Clinebell*, Basic Types of Pastoral Care and Counseling: Resources for the Ministry of Healing and* Growth (Nashville, Tennessee: Abingdon Press, 1984), 141-157, 170-173.

constitute a powerful reminder of the healing, sustaining, guiding, and reconciling power of religious faith. They show compassion, care, and empathize with patients.

2.8.5 Conduct Bereavement Services

The chaplains design and lead religious ceremonies and run funeral services in the hospital. Granger Wester remarks that the vulnerable ones in the hospital need spiritual support.[102] Chaplains bring wholeness through prayer, provide a presence through listening, and heal through emotional support.[103] To the patient, the chaplain serves as a faithful companion, comforter, presence, storyteller, especially during difficult medical circumstances. Chaplains offer a supportive presence that serves to remind patients and caregivers that people are more than just their medical conditions or their current collection of concerns.

2.8.6 Mediating Role

Chaplains function as advocates between staff and administration and between patients and staff. Health Care Chaplains, whose primary role is to provide spiritual care to patients, their families, and medical staff, are sometimes asked for help in making complex decisions and resolving conflicts. By asking them to become mediators in conflicts over patients' medical care, over conflicts between staff and administration shows they recognize their competence. Chaplains act as mediators and reconcilers. To the family, chaplains serve as a mediator between clients, families, as well as the healthcare team. To fellow staff members chaplains also provide counseling, debriefing, and moral support. They work to reconcile staff to administration by resolving conflicts

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[102] Granger Wester. *Nurse, Pastor, and Patient* (Illinois: Augustana Press, 1995),1955, 73-75.
[103] Cadge, Calle, and Dellinger, *What Do Chaplains Contribute to Large Academic Hospitals*.

peacefully and promoting health and wellness, equality of services offered, access to resources, individual rights, and care.

2.8.7 Ethics Committee

A hospital's ethics committee is an MDT that may include not only physicians, medical services, administrators, chaplains, social workers, and community representatives, but also risk management, legal, and regulatory member, and often a health system ethicist. Hospital chaplains are often at the forefront of dealing with end-of-life issues and decision making with family members.[104] They are well versed in ethics and ethical thinking and can provide important input when ethical conflicts arise. Having a chaplain on the ethics committee is essential for the committees to maintain a multidimensional approach to holistic care.[105] Tullio Proserpio states that the chaplains should balance ethics and faith as well as act as a bridge between physicians and their patients or the patients' relatives.[106] Chaplains may serve on ethics committees and critical incident stress management team, administrative teams, or work with education departments to teach physicians, nurses, and other hospital staff about issues surrounding death, cultural diversity, faith, stress, or spiritual assessment.[107]

2.9.8 Research

Vanderbeek noted that chaplains and their certifying organizations encourage and support research so that there can be stay relevant and informed.[108]

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[104] Esquive, "*Application of Clinical Ethics*," 4-10.

[105] Esquivel, *Application of Clinical Ethics*, 4-5.

[106] Tullio Proserpio, Claudia Piccinelli, and Carlo Alfredo Clerici, "*Pastoral Care in Hospitals: A Literature Review*,"97, no.5 (2011): 669-669. DOI:10.1700/989.10729.

[107] Dawn and Schipani. *Spiritual Caregiving*, 49.

[108] Larry VanDerBeeks and Laurel Burton, "*Professional Chaplaincy: Its Role and Importance in Healthcar*e," 55, no. 1 (March 2001):81-97, https://doi:10.1177/002234090105500109.

Becoming integrated as a hospital chaplain requires personal and professional effort on the part of everyone involved. For teams to be effective, all members should be free to initiate MDT relationships, speak out about the spiritual dimension, and hold the team accountable for addressing these needs. If the chaplain is to be integrated into the rounds and conferences on various units, he or she will need to be visible and available when the team meets, or to take proactive leadership in attending patient care conferences.[109] Excluding them is an error for the team and the institution. Cobb, says that chaplains like their fellow healthcare team members, also access patient medical records and document in the patient's electronic medical records or chart flow sheets of patients to document all what they have spoken with patients as work not charted is work not done[110]

2.9 Spiritual Care

Clinebell states that chaplains are healthcare professionals dedicated to engaging patients about spiritual concerns and easing patient suffering, often by listening, showing compassion, empathy, empowering, offering hope, and providing unconditional support.[111] O'Connor, Patrice who is at the palliative Care Program at St. Luke New York notes that spiritual care refers to the ability of a person to find solace, comfort, connection, meaning, and purpose amid suffering, disarray, and pain. The care is rooted in spirituality through compassion, hopefulness, and the recognition that although a person's life may be limited or no longer socially productive, it remains full of possibility.[112]

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[109] Dawn and Schipani. *Spiritual caregiving*, 50-51.

[110] Cobb, M. *"Change and Challenge: The Dynamic of Chaplaincy*. "Scottish Journal of Healthcare Chaplaincy 10, no. 1 (2007): 4-10, DOI**:** https://doi.org/10.1558/hscc.v10i1.4

[111] Clinebell, *Pastoral care*, 70-72.

[112]Parice O'Connor, *The Role of Spiritual Care in Hospice: Are We Meeting Patient's Needs*? American Journal of Hospice Care, 5, no.4 (1988): 31-37, doi: 10.1177/104990918800500411

Wilfred, McSherry a health care professor states that chaplain's role on the care team is to address those spiritual needs that might surface in the patients. Chaplains are spiritual experts when it comes to addressing spiritual issues within the hospital because they understand boundaries and respect religious differences.[113] Integration of spiritual care requires spiritual competences, and this can be done by a chaplain who is trained to assess and deal with a variety of spiritual needs, hopes, and resources of patients, families, and staff.[114] Koenig makes it clear that there is increasing evidence that patients rely on their spiritual and religious beliefs and want their religious and spiritual values considered in planning their care.[115]

Therefore, it is wrong to imagine that a person's spirituality, or indeed their spiritual needs, will be left at the entrance of the hospital or outside the care setting. It is in these crisis times that the search for meaning, and spirituality makes sense in patients' lives.[116] Koenig says that an illness in a patient or hospitalization may see a refocusing or questioning of their spirituality. An illness, or indeed any crisis, may function as a trigger that moves the patients to revisit, encounter, or get in touch with their own spirituality.[117] However, not all patients will present a spiritual need, or even raise any existential because of their illness.[118]

Stephen Wright has been quoted in a Scottish government medical journal that Spirituality and healing are part of health, not peripheral but core and central to it for it pervades our every thought and action, and each caring moment.[119] Spiritual care and

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[113] Christina Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality into Patient Care* (Templeton Press, 2010), 55.

[114] Wilfred McSherry, and Linda Ross, *Spiritual Assessment in Healthcare Practice*, (M and K ltd, 2010), 97,

[115] Koenig H. G. "Religious Attitudes, and Practices of Hospitalized Medically Ill Older Adults," 13, no.4 (1998): 214-220, doi: 10.1002/(sici)1099-1166(199804)13:4.

[116] Koenig, "Religious Attitudes," 223-227.

[117] McSherry and Ross. *Making Sense of Spirituality*, 97-98.

[118] Koenig, "*Religious Attitudes*," 223-227.

health are bonded to each other, inseparable companions in the dance of joy and sadness, health and illness, birth, and death.[120]

Miller, W. holds his view that spirituality is deeply personal and involves an individual's deepest fears and aspirations. It provides individuals with a worldview and a context in which to view life and its meaning.[121] The spirituality of a patient most often remains unseen, undiagnosed, untreated, and not integrated into the whole care plan until the patient expresses the need for spiritual care.[122]

Christina Puchalski a professor in palliative care highlights that Spiritual care offers a framework for health care professionals to connect with their patients, listen to their fears, dreams, pain, and collaborate with their patients as partners in their care. McSherry echoes that this will provide therapeutic relationship which is an opportunity for healing.[123] Spiritual care can be considered as the recognition and acceptance of a patient's sense of meaning and purpose in life, which may or may not be expressed through formal religious beliefs and practices. Spiritual care refers to interventions made by chaplain to address patients' spiritual needs.[124]

2.9.1 Some Facts About Spiritual Care from different Authors

Cobbs mentions that when patients experience a spiritual crisis and need spiritual care, they may choose to discuss their concerns only if they have been shown respect and

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120 *Spiritual Care and Chaplaincy*, 30 January 2009, https://www.gov.scot/publications/spiritual-care-chaplaincy.

121 Miller W. *Integrating Spirituality into Treatment: Resources for Practitioners* (Washington, DC: American Psychological Association 1999).

121 Puchalski and Ferrell, *Making Health Care Whole*, 55-56.

122 Puchalski and Ferrell, *Making Health Care Whole*, 55-56.

123 McSherry and Ross, Making *Sense of Spirituality,* 75.

124 Augustine Meier, et al., *Spirituality and Health: Multidisciplinary Explorations* (Wilfrid: Laurier University Press, 2005), 22-25.

appreciation accordingly.[125] Chaplaincy care is specialized spiritual care provided by board certified chaplains. Berggren and Thomas states that spiritual care is that which involves promoting an individual's personal integrity, interpersonal relationships, and search for meaning.[126]According to journal titled the impact of professional care, it states that spiritual care giving is not only providing but empowers the patient to build resilience.

Monty, C. Wright, a lead pastor in the church says that Spiritual care is based on empathy and nonjudgmental love, it affirms the worth of each person and, it responds to both religious and nonreligious needs of the patients and families.[127]

Puchalski says that spiritual suffering or distress may also be manifested as physical pain, depression or anxiety, social isolation, and spiritual or existential distress. Pain is multidimensional and may be exacerbated or relieved by attention to the other dimensions of suffering. Spiritual suffering or pain may manifest within various domains of the patient's experience, be it physical (e.g., intractable pain), psychological (e.g., anxiety, depression, hopelessness), religious (e.g., crisis of faith, anger at God), or social (e.g., disintegration of human relationships). One patient's suffering may be predominantly spiritual; another may be mostly psychological. Suffering is difficult to diagnose based on symptoms alone.

Many patients and their families will not use the word spiritual but that does not cancel the fact that they are experiencing spiritual issues. Spiritual struggle is always

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125 Cobb M, and Robshaw, *The Spiritual Challenge of Health Care (*Edinburgh: Churchill Livingstone. 1998), 112.

126 Berggren- Thomas Griggs, M. "Spirituality in Aging: Spiritual Need or Spiritual Journey?" 21, no. 3 (1995): 5-10, Doi: 10.3928/0098-9134-19950301.

127 Monty. C. "Wright, *The Essence of Spiritual Care: A Phenomenological Enquiry*," *Palliative Medicine*, 78, no. 2, (2002), 125-137.

revealed as a change or loss of meaning and, sometimes, trying to reconstruct what is purposeful.[128]

Caroline Young and Cyndie koopsen a nurse and an author of the book Spirituality, Health, and Healing and Integrative Health: A Holistic Approach for Health Professionals state that

2.9.2 Spiritual distress

This is a state in which an individual is experiencing a disruption in the values or beliefs that provide the individual with strength, hope, and meaning. A spiritual crisis or distress occurs when patients cannot find meaning, hope, love, peace, or strength in their lives.[129] Clients in spiritual distress may say they are broken hearted, or their spirits are down, they may talk about feelings of being abandoned by God or by others or may have doubts about religious or spiritual beliefs. This goes with spiritual pain, spiritual alienation.[130]

McSherry observed that if we all have a spirituality and spiritual needs, then logically it must follow that when a crisis or sudden event occurs in life, we may experience not only physical, psychological, and social distress but also spiritual distress.[131] Spiritual distress is the result of total inability to invest life with meaning. This happens with loss of function, dispiritedness and a recognition of behavior or feelings that convey an altered spiritual integrity.[132]

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128 *The-Impact of-Professional-Spiritual-Care. ACPE: The Standard for Spiritual Care & Education*, June 2019. https://www.westchestermedicalcenter.org/chapaaincy.

129 Young, Cyndie, and Koopsen, *Spirituality, Health, and Healing* (Jones and Bartlett, 2005), 118.

130 Young, Cyndie, and Koopsen, *Spirituality, Health, and Healing*, 115-118.

132 McSherry and Ross. *Making sense of spirituality*,56.

2.9.3 Systematic Approach to Spiritual Care

Ian Grovier, a nurse, brings out a systematic approach to the spiritual care of any client which is appropriate and effective as follows.

2.9.3.1 A. Spiritual Assessment

McSherry says that spiritual assessment is an extensive, in-depth, and ongoing process of actively listening to a patient's story as it unfolds in a session, and to summarize the needs and resources that have emerged for proper interventions.[133] George, Fitchett, a director of research in the department of religion and health affirms that assessment guides and help the chaplain to set goals for ministry.[134] Therefore, spiritual assessment is an attempt to enquire positively and unobtrusively with a patient or his or her care giver into areas of life that are associated with their health and well-being. McSherry clarifies that assessment is an exploration of the person's psychosocial and spiritual functioning which may be written or verbal. It requires chaplains to be competent and possess self-awareness regarding their own spiritual dimensions and the creation.[135] McSherry noted that spiritual assessment is not about imposing a set of rigid questions on patients but about interaction and dialogue between the patient and the chaplain.[136] This dialogue should always be initiated and guided by the chaplain, although on admission to any healthcare setting, there should always be some formal enquiring into a person's religious and non-religious belief so that this can be documented with patients' consent.[137] Assessment is the first step to a holistic process in

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133 McSherry and Ross, *Spiritual Assessment,*58-59**.**

134 George Fitchett, *Assessing Spiritual Needs: A Guide for Caregivers* (Ohio: Academic Renewal Press, 2002), 20-23.

135 VandeCreek and Burton, "Professional Chaplaincy," 80-90.

136 McSherry and Ross, *Spiritual Assessment,* 61-62.

137McSherry, and Ross, *Spiritual Assessment,* 62-63.

a patient's health.[138] Without a thorough and careful assessment, effective interventions are compromised.[139]

2.9.3.2 The Importance of Spiritual Assessments

Hodge Dr elaborates that "assessments help to provide effective, culturally sensitive services while concurrently providing a forum to explore spiritual strengths that might be used to ameliorate problems or cope with difficulties."[140] Fitchett addresses this in his writings by outlining several advantages which are:

2.9.3.2.1 It provides a foundation for Action.

Assessments help set and clarify goals for caregivers and patients. It provides a deeper understanding about a person from a holistic perspective. It helps chaplains to understand the patients' basic world view of the patients and relationships with God and self.[141]

2.9.3.2.2.3 It provides a foundation for Communication.

It brings the caregiver and patient to the clearest possible description of the situation at hand.

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[138] Wicks, et. al., Clinical *Handbook.*

[139] Ian Govier, "Spiritual care in nursing: A systematic approach," *Nursing Standard,*14, no.17, (2000s): 32-36.

[140] Hodge DR. "Developing a spiritual assessment toolbox: a discussion of the strengths and limitations of five different assessment method," *Health Social Work* no.4 (November,2005): 314-23. doi: 10.1093/hsw/30.4.314. PMID: 16323723/Accessed, December,2023.

[141] Young, and Koopsen, *Spirituality*, 115-119.

2.9.3.2.4 It provides a foundation for Contracting.

It allows the caregiver to seek further support from other hospital departments. It helps predict health outcomes because they provide valuable information to the members of the health care team about the individual's ability to cope, and the possible interventions that would help patient cope with the health care crisis they may be facing.

2.9.3.2.4 It provides a foundation for Evaluation.

It provides the basis for knowing if the treatment plan has been successful or unsuccessful.

2.9.3.2.5 It provides a foundation for Accountability.

It allows for personal accountability between caregiver and patient for treatment being given.[142] Young comments that for spiritual care to be effective, it should be loaded with benefits which are:

2.9.4 B Planning Spiritual Care

Young says that once the assessment has been completed, the information gained can be used to formulate an effective plan of spiritual care. A spiritual care plan should reflect the needs identified during the assessment phase.[143]The information should be verified with the client, and it should be realistic. The goals should be client- centered. Planning mutually upon goals for action creates a good atmosphere for interventions and implementation. [144] When assessment is not well-done, planning can be difficult. Effective communication between the client, family, friends, and other members of the

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[142] George Fitchett, *Assessing Spiritual Needs: A Guide for Caregivers* (Ohio: Renewal Press, 2002), 20-25.

[143] Young, Cyndie, Koopsen, *Spirituality, Health, and Healing*, 117.

[144] Young, Cyndie, and Koopsen, *Spirituality,* 118.

health care team is essential at this juncture.[145] Assessment direct our attention and our communication.

Stephen Roberts a Jewish board-certified chaplain states that chaplains are to provide substantial details and specificity about the care they have provided to patients. When chaplains simply state in their record that "pastoral presence or spiritual care has been provided," It is general, and its meaning is less transparent. So, they should expound on their documentation for clarity.[146] Caroline supports this idea by suggesting that spiritual health affects physical and psychological health and, therefore, should be given a high priority when planning care, especially if the client is diagnosed with spiritual issues.

2.9.5 C Interventions

Young gives some Interventions tools which are**,** caring touch, fostering connectedness between the client and his or her family, friends, analyzing dreams, reading spiritually uplifting materials, meditation, or prayer, encouraging journal writing or scrapbook making, incorporating storytelling, or life review into care plans.[147] Christina agrees with this statement as she remarks that spiritual intervention include a variety of activities and processes such as spiritual counseling, encouraging patients to utilize already established spiritual practices for example, prayer, meditation, participation in spiritual or faith communities, meaning-centered therapy, dignity therapy, journaling, and participation in the arts.[148] Other effective tools for implementing spiritual care include the use of intuition and appropriate behavioral interventions, both of which depend on the level of self- awareness possessed by the chaplain.

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[145] McSherry and Ross, *Making sense of spirituality*, 70.

[146] Stephen Roberts, *Professional spiritual care*: *A practical clergy and chaplain handbook* (Woodstock, 2016), 50—60.

[147] Young, Cyndie, and Koopsen, *Spirituality, Health, and Healing,* 119-121.

[148] Puchalski and Ferrell, *Making health care Whole*, 112-113.

2.9.5.1 Why should the Chaplain Meet Spiritual Needs of Patients?

Christina in his book Medicine, Religion, and health: Where Science Meet, gives some reasons as follows.[149]

A The first reason is that many patients are religious, and the majority would like their faith to be considered in their health care. This is true because by nature, we are spiritual beings and when our spiritual needs are not met, we cannot be whole. It should not be surprising, then, that failure to meet emotional and spiritual needs is one of the most common complaints of patients on post-hospitalization surveys.[150]

B Religious beliefs and practices may influence medical outcomes. Given the adverse effects of stress on the body, when patients' spiritual and emotional needs are unmet, this is likely to affect their immune, endocrine, and cardiovascular systems in ways that could influence the way they respond to surgical and medical treatments. Such effects on physical outcomes, in addition to the influence of negative emotions on treatment adherence, medication compliance, and motivation toward self-care, are likely to affect the patient's medical condition directly or indirectly.[151]

C The third reason for learning and addressing spiritual needs is that patients are often isolated from other sources of religious help. People may be hospitalized far away from their faith communities, and long travel distances may prevent clergy and church members from visiting them. The result is that patients are often isolated from the kinds of spiritual support that is tailored to their specific medical condition.

D Finally, spiritual beliefs and commitments influence the type of health care and monitoring that a patient receives in the community after he or she leaves the hospital or doctor's office.[152] The nurse might not be the right person to handle the spiritual needs of

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[149] Fitchett et al., *Medicine, Religion, and Health*, 158.
[150] Fitchett et al., *Medicine, Religion, and Health*, 157.
[151] Fitchette et al., *Medicine, Religion, and Health*, 158.
[152] Fitchett et al., *Medicine, Religion, and Health*, 159-160.

patients because in so doing, it can be uncomfortable for the nurse due to embarrassment, lack of training, and spiritual resources, and lack of knowledge in spirituality.[153]

2.9.6 Evaluating the individual's status after the intervention.

Fitchett sates that when all the first three steps have been completed, an evaluation of those steps is necessary to determine their effectiveness.[154] One difficulty with evaluating whether they are spiritual or not spiritual is the time frame involved in achieving them. It may take a patient many months to resolve a health problem or a personal crisis. It is unrealistic to expect a patient to reflect, adjust, and regain his or her spiritual balance in a matter of hours, days, or even weeks.[155] Thus, the specific spiritual needs of a patient should be carefully considered and time frames for implementation and evaluation of spiritual goals realistically decided.[156]

2.9.7 How Does the Chaplain Play his Role in Documenting Work Done?

Recording work done.

After assessment, planning, interventions, evaluation, and recording is important because "if It Was not 't Charted, It Was Done.") Documentation should stay with facts and observations. The language we use should be grounded in our professional field and work we do as chaplains.[157] While we want the health care team to know what we have learned, accomplished, and planned; the chart is the legal document for the chaplain to

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153 McSherry and Ross, *Making sense*, 127-136.

154 Young, Cyndie, and Koopsen, *Spirituality, Health, and Healing,* 104-108.

155 Young, Cyndie, and Koopsen, *Spirituality, Health, and Healing,* 120.

156 Young, Cyndie, and Koopsen, *Spirituality, Health, and Healing,* 120-121.

157 Stephen Roberts. *Professional Spiritual and Pastoral care: A practical Clergy and Chaplains' Handbook* (Starlight paths, 2021), 83.

use.[158] This applies to spiritual care as well as to every other aspect of care. Fitchette states that the patient's medical record is usually a compilation of entries from multiple care providers and needs to be taken seriously. Where healthcare chaplaincy is an established service, the chaplain aspires to document information relevant to a patient's overall care.[159] Chaplains should always be aware that their notes might be read by patients, staff who do not know them and so be discrete as to what is needed for they can be part of court cases and legal proceedings.[160] Regarding documentation, Puchalski says it should be detailed as he states that documenting essential aspects of the patient spirituality by simply stating that he is a Baptist, catholic, Presbyterian is not so sufficient. The chaplain should endeavor to include spiritual beliefs, values, practices as part of his documentation.[161] While general standards of practice exist, specific clinical practice guidelines on the function of spiritual care documentation are evolving. Fitchettesays that the World Health Organization (WHO) had mentioned that assessment should be expected to include data about explicit religious beliefs and practices, the role played by spirituality and religion in coping with illness, spiritual, and existential suffering caused by illness, accident, or the anticipated death of a loved one.[162] This is crucial because the inclusion of spiritual needs of both patient and family is considered essential to the whole person.

2.10 Chaplains and Referrals

Robert, Wicks who had been a therapist and social worker says that the process of referral is an important part of healing experience of the patient seeking wholeness.[163]

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[158] Roberts, Professional Spiritual and *Pastoral care*, 82.
[159] Fitchette, et al., *Evidence-Based Healthcare Chaplaincy*, 85.
[160] Roberts, *Professional Spiritual and Pastoral care ,83.*
[161] Puchalski and Ferrell, *Making health care Whole*, 135-136.
[162] Fitchette, *Evidence-Based Healthcare Chaplaincy*, 100.
[163] Wicks., et al., *Clinical Handbook of Pastoral Counselling*, 166-167.

In order for the referral process to be an extension of the healing ministry of Christ, the chaplain should take sound professional judgement regarding the nature of the needs of the patient.[164] Laura, Vanderwerker, in a journal titled, topography of referrals say that understanding referral patterns to chaplains is essential not only to ensure proper patient treatment, but also to assist chaplains seeking to expand the range of patient situations in which they are called to intervene.[165] The chaplains should recognize and understand their own limitations and utilize other available professional resources wherever and whenever appropriate as well. This is because referrals are not a weakness but a strength. Wicks confirms this as he states that a chaplain who refers a patient to a member of the MDT for more specialized care extends the effectiveness of his own ministry of healing. Christina affirms the importance of referrals. Just as non-chaplain clinicians need to refer to chaplains for more specialized spiritual issues, chaplains refer to other clinicians for issues related to other disciplines or areas of expertise. For example, a chaplain may identify depression or anxiety and would refer to a social worker, psychologist, or psychiatrist.[166]

2.11 The Ministry of Presence

Chaplaincy ministry has often been called the ministry of presence because chaplains are ready and able to meet patients where they are as an extension of God's presence to them. Ministry of Presence speaks to the heart of chaplaincy because it deals with the history and definition of chaplaincy as well as the chaplain's call to ministry.[167] Presence is a term used frequently when chaplains are to describe their work. The

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164 Wicks., et al. *Clinical Handbook of Pastoral Counselling*, 168-169.

165 Lauren C. Vanderwerker, et al. "Topography of Referrals to Chaplains in the Metropolitan Chaplaincy Study*,"* 63, no.3 (March 1, 2009): 1-10, https://doi.org/10.1177/154230500906300106.

166 Puchalski and Ferrell, *Making health Care Whole*, 133.

167 Whit Woodard, *Ministry of Presence: Biblical Insight on Christian Chaplaincy* (Faithful Life Publisher, 2011), ii-10.

hospital chaplain is a "faith presence" personality that accompanies each patient on their journey through life. He is open, accepting, sharing, respecting, learning, and invitatory. Through the strength of this relationship, the chaplain in turn can become a faith presence for others. This means being with others and paying attention to the quality of that being with. Neil Holm, says that the chaplain, as faith presence, is open, accepting, respecting, sharing, learning and Invitatory.[168]

Chaplains begin by being present with a patient, so that the chaplain is open to creating new meaning with the one who suffers. He remarks that the chaplain, through his or her presence can help restore to the patient the opportunity to feel some control, a sense of power, and a sense of "purpose," to experience being loved and to express love.[169] Lawrence who is involve in ministry publication states that Jesus modeled a ministry of presence throughout his life. The greatest reminder a ministry of presence can designate is the mere validation that God is still there for you. Chaplains help to affirm this to their patients.[170] Carl Rogers an American psychologist says that for a chaplain to have a therapeutic relationship with a patient, five things are required which are, being congruent, being positive, accepting, being empathic, and being present.[171]

Jacqueline, Thomas remarks that chaplains demonstrate God's presence through their own presence and actions by a conscious choice to be physically present with the client and by emotionally present with the client through empathetic listening. [172] Through presence the chaplain begins to build the relationship that eventually brings

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168 Neil Holm, Toward a Theology of the Ministry of Presence in Chaplaincy, 52, no. 1 (May,2009): 7-10. DOI:10.1177/002196570905200103.

169 Millspaugh D, Assessment and response to spiritual pain: Part 1. Journal of Palliative Medicine, Vol8 no5 (2005a): 919 – 923.

170 Rachel V. Lawrence, "The Theology of Chaplaincy: Having a Ministry of Presence" (PhD diss., Fuller Theological Seminary, July 2015),4-6.

171 Carl Rogers, The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21, no.2 (1975): 90-103. https://doi.org/10.1037/h0045357.

172 Jacqueline Mary Thomas, "Voicing the spiritual: A Dynamic Exploration and Analysis of the Role of the Chaplain in English Hospices" (PhD Thess. University of Surrey October 2016),148.

comfort to those who feel alone in their suffering or despair. To the chaplain it is about being around, being available, as a symbol of the presence of God. Paget says that the presence of God in the person and ministry of the chaplain means empowering, healing, victory, comfort, sufficiency and connected to the presence of God.[173]The ministry of presence is identified as being there in such a way that the other person defines it as meaningful.

At times, this ministry of Presence is frustrating because both the chaplain and the patient may perceive that nothing is happening. Paget, a certified chaplain testifies that the ministry of presence is the graceful gift that chaplains bring to the human encounter. It is being physically present even when the surroundings seem threatening. It is being emotionally present although the anger or fear is uncomfortable. Chaplaincy is very quickly becoming defined as a 'ministry of presence,' as more chaplains find that effective pastoral care takes place from the "being" and not just the "doing."[174] Presence is the graceful gift that accepts the client who seems unacceptable.[175]

The chaplain won't be able to fix problems, but the chaplain's presence is a reminder that spirituality is a part of the ordinary and extraordinary activities of life.[176] Sharing the moment of crisis through the ministry of presence may be the most powerful and appreciated act of ministry performed by the chaplain. The presence of God in the person and ministry of the chaplain empowers the client to healing and wholeness.[177] Holm states that chaplains practice the presence of God through prayer, rites, rituals, listening, the spoken word, Bible, and acts of service.[178] They share God's presence with

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[173] Paget and McCormac. *The work of the Chaplain*, 27- 28.

[174] Peter R. Laughlin. "A Trinitarian Ministry of Presence: An Encounter of Meaning in Christian Chaplaincy" 6, no.3 (November 2015): 1-5, https://www.academia.edu.

[175] Paget and McCormac. *The work of the Chaplain* ,25.

[176] Paget and McCormac. *The work of the Chaplain*, 26.

[177] Paget and McCormac. *The work of the Chaplain,* 27.

[178] Holm, *Toward a Theology,* 8.

clients even as they share their own presence and words of assurance "I am with you." By being with the patient, the chaplain incarnates the love and the presence of God.[179]

2.12 The Advocacy and Prophetic Voice Role of the Chaplain

2.12.1 The Chaplain as An Advocate

Easton's Bible Dictionary defines an advocate as a person who represents another person's interest, one who pleads another's cause, who helps another by defending, interceding, or comforting him.[180] An advocate may promote a specific position, or simply stand in favor of a certain result. Chaplains serve as intercessors or advocates in for the patient and for the institution especially in unusual or unexpected circumstances.[181]

The scriptures make it clear that the Holy Spirit is our paraclete in John 14:16. The word "paraclete" comes from the Greek word parakletos, which means "advocate," "comforter" or "counselor" or "one called to the side of another.[182] Jesus Christ is also called our advocate in 1John2:1.

An advocate is someone who speaks for others. In the same way, a chaplain advocates for patients, staff, institutions when he offers advice, counsels, provides supporting evidence or testimony, or acts as a mediator on that person's behalf.[183] Jeffery Hayman suggests that hospital chaplains are the advocates between the hospital administrators, the MDT, the patient's family, and the patients. They are the go-between when a person needs conflict resolution, especially when patients need to regain their

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179 VandeCreek. *Spiritual Needs and Pastoral Services,* 1995,185.

180 Bible Dictionary, https://www.biblestudytools.com/dictionary/advocate.

181 Paget and McCormac. *The work of the Chaplain*,25.

182 Wayne Grudem, *Systematic Theology: An Introduction to Biblical Doctrine* (Grand Rapids, MI: Zondervan, 1994), 600.

183 Paget and McCormac. *The Work OF The Chaplain*, 24.

independent voices[184] The chaplain acts as an institutional advocate by assisting an organization in personnel issues by clarifying appropriate action, suitable outcomes, right behavior, or proper protocol it is a priority for all chaplains who are employed by institutions, both private and public.[185] When there is a misunderstanding between employees or clients and the institution, the chaplain often acts as an advocate for both groups.[186] In doing so, the chaplain clarifies issues, presents both positions, and often advises and arbitrates. Naomi explains that as an institutional advocate, the chaplain helps the institution to be sensitive to employees' issues and needs while protecting the integrity and mission of the institution.

2.12.2 The Prophetic Voice of the Chaplain

The chaplain with his prophetic voice is perceived to challenge unjust structures which is a significant model in this literature.[187]Ballard says that the prophetic approach to chaplaincy is unworkable as the push towards professionalism requires chaplains to demonstrate institutional loyalty.[188] Chaplains should not take a neutral stand in the face of injustice.[189] Ballard states that the there is need for chaplains to act as advocates by speaking out. This is important because the chaplains as spiritual leaders of the institution must ensure that their prophetic voice is louder in decision making and, in all departments, than the voice of others.

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184 Jeffrey D. Hayman, "Understanding the 21st Century Practical Implications of Chaplaincy Ministry in the City of Milwaukee, WI" (PhD diss., Liberty University John W. Rawlings School of Divinity December 2022), 9-10.

185 Hayman, *Understanding the 21st Century Practical Implications,* 10-11.

186 Hayman, *Understanding the 21st Century Practical Implications,* 11.

187 Pattison al., *Emerging Values in Healthcare.*

188 Ballard, *Emerging Values in Healthcare,*191.

189 Stephen Pattison, *Pastoral Care and Liberation Theolog*y (Cambridge: Cambridge University Press 1994), 80-90,

Anne Aldridge explains that chaplains have a distinctive role with a Prophetic voice - standing out in the face of injustice or unethical issues. This can show itself in the role of arbitrator between peoples, staff, patients, and families.[190] Lyall affirms that many problems and public scandals within institutions do not occur precisely because a chaplain has been in the right place at the right time.[191] Pattison commented that when a chaplain is neutral, there is more on the inside which is unhealthy and this could be compromise, because of a refusal to speak the truth for fear repercussion. Someone once said that the chaplains` voice is muted because of money, injustices and even their own lifestyle. The voices of chaplains should be heard if we are to take seriously the nature of the chaplains' pastoral encounters and their role within the health service. This will help loud the poor perception. Wood said that when a chaplain depends upon the hospital for validation and security, it takes courage for him to point out wrong.[192] Waterson who was a publisher says in his book that chaplains often find it difficult to play the prophetic, to criticize the system of which they are a very integral part of. To be a prophet in a system upon which you depend for your livelihood is difficult and requires prophetic courage.[193] Vandecreek states that many times the truth is spoken not in words but in deeds which has led the institution to where it would go.[194]

As a prophet to the patients, there is space to talk about what has been helpful to patients and how a chaplain can support them cope emotionally and spiritually. Also, prophetic can happen in the way of naming what the patient is experiencing through assessment so that interventions are done.

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190 Anne Aldridge, "The unique role of a chaplain," *Scottish Journal of Healthcare Chaplaincy* 9, no. 1. (April,2006): 21.

191 Lyall, *"Integrity of Pastoral Care,"* 41.

192 Pattison et al*., Emerging Values in Healthcare, 95*

193 John Waterson, "*Tell it to the Chaplain: Medicine and Health* R I," 80, no.4 (April ,1997): 114-124.

194 Vandecreek, *Professional Chaplaincy*, 26.

2.13 The Multidisciplinary Team

David, Belgum, a coordinator of CPE in the School of Medicine. says that MDT is a professional group of therapists and technicians who contribute to the care of the patient.[195] Dawn states that when people from various professions collaborate with one another daily in the hospital, they may think of themselves as being an MDT. Belgum acknowledges that many trained specialists work side by side with other member of the MDT yet are legally not allowed to perform the services of the other colleagues and so it will not be healthy for nurses to perform the chaplains' role as some do.[196] The one requirement which is most noted about an MDT is that the team is comprised of workers from different disciplines within the hospital. Godlove states that holistic care requires the social, physical, mental, and spiritual aspects which can be achieved by the MDT.[197]

Therefore, for the team to meet these components, the chaplain should be a part and partial of the team. Jerry Nussbaum a chaplain and perinatal grief coordinator at Mount Carmel Health System in Columbus made a statement that current literature strongly affirms the notion that we as humans are multidimensional and that our physical, emotional, spiritual, and mental capacities are connected and interrelated. If one is neglected the body suffers.[198]

Dawn confirms that medical journals are now integrating the spiritual, physical, emotional, mental, social, and cultural aspects of our lives.[199] However, there is a lack of awareness of the role and function of the chaplain, on the MDT thus excluding the chaplain from being in the health care plan. MDT has a diversity of individuals based on the care of the patient. The team provides hope, counsel, guidance, and treatment to

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195 Belgum, *Clinical Training for Pastoral Care*, 21-22.

196 Belgum, *Clinical Training for Pastoral Care*, 25.

197 Godlove Ndongndeh, *Centre for Clinical Pastoral Education and Social Services: Student Handbook* (Bamenda: Cameroon Baptist Convention press, 2010), 21-30.

198 Vandecreek and Burton, *The Chaplain -Physician Relationship*, 50-60.

199 Dawn and Schipani. *Spiritual Caregiving,* 36.

addressing every aspect of the individual. Specialization is a typical characteristic of the average modern hospital. The role and function of the hospital chaplain has often been a debatable and misunderstood issue within the context of the hospital and, more specifically, the MDT team.

Due to the fact spiritual values are a part of patient care, it gives the understanding to the medical team that they need to work together to develop relationships with each other and better provide holistic care to the patient.[200] Chaplains add value to the teams as well as a meaningful contribution. To understand how the care of the patient is to be accessed, the chaplain becomes an essential part of the team through relationships with one another and the care of the patient.[201] Often, when dealing with a patient, there are many areas and issues which need addressing. Each member of the healthcare team has an area they address. Therefore, there is an importance on collaborating in a team as a means of understanding how each other's role and function fit into providing appropriate care to patients.[202]

Neville Kirkwood, who has served as a chaplain, states that MDT chaplains are part of the specialized professional therapeutic team working within the hospital. They are expected to have undertaken CPE or other supervised pastoral counseling training to develop the specialized skills for this profession.[203] This earns them a place alongside doctors, nurses, and other health workers in the total care of the patient. They are often in consultation with the other team members in protocol for the patient. In fact, the distinctive role of the chaplain is fast becoming recognized as an essential requirement of

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[200] Cadge, *Paging God, 56.*

[201] Christopher J. L. Cunningham et al., "Perceptions of Chaplains' Value and Impact Within Hospital Care Teams," 56, no. 4 (June, 2017): 12-31, https://doi:10.1007/s10943-017-0418-9.

[202] Patrick Hemming et al., "Chaplains on the Medical Team: A Qualitative Analysis of an Interprofessional Curriculum for Internal Medicine Residents and Chaplain Interns,"55, no. 2 (04, 2016): 560, DOI: 10.1007/s10943-015-0158-7.

[203] Ndongndeh, *Centre for clinical Pastoral Education*, 28-35.

the hospital program.[204] Dawn asked a question which is worth giving attention to. Who is responsible for spiritual care, especially in the context of MDT? Is it the chaplain? the physician? Or the entire team? The obvious answer is that it is the chaplain. As a spiritual care specialist, he has the appropriate training and expertise it takes for spiritual care.[205]

Chaplain Mark LaRocca-Pitts uses a term for the chaplain called the Hospitalist as an analogy for describing the role of a hospital chaplain.[206] LaRocca-Pitts clarifies that as a metaphor, the hospitalist is compared to primary care physician (PCP) as the chaplain is compared to local clergy. As a spiritual care specialist, he works with the MDT that focuses on treating the person. Identifying the chaplain's specialized role helps lessen boundary and training concerns and provides a model of holistic care.[207]

Dawn expands his thoughts by recapitulating that the chaplain, as spiritual specialist on the MDT brings at least four additional contributions to the team which are sensitivity to multicultural and multifaith issues; broad understanding of the impact of illness, trauma and crisis faith, belief, and the spiritual search for meaning.[208] This is important because when the team senses hopelessness, distress and spiritual concerns, the chaplain as a specialist takes the responsibility.

Anne Aldridge concord that the chaplain as part of a team is integral to the current healthcare ethos in providing client-centered, holistic care.[209] When members of the MDT have a MDT approach, the patients' needs are met, and thus holistic care is achieved through a multidimensional approach that includes medical, social, spiritual, psychological, and emotional needs. A MDT's effectiveness depends on collaborative leadership and attention to group dynamics. By group dynamics, I mean what made us

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204 Kirkwood, *Pastoral Care in Hospita*l, 170-171.
205 Dawn and Schipani. *Spiritual Care in the Hospital,* 37-38.
206 Dawn and Schipani. *Spiritual Care in the Hospital, 37.*
207 Dawn and Schipani. *Spiritual Care in the Hospital,* 37-40.
208 Dawn and Schipani. *Spiritual Care in the Hospital*, 42-43.
209 Aldridge, 21-22.

come together as a team, each team member's role with respect to a patient's need, and how issues arising can be addressed in the team.

According to Skanse, John a chaplain at St clouds hospital, everyone who engages in a patient's care is there because of their expertise. The expertise of a care-provider is the easiest way to quantify and explain the value of that worker. To be quantified, it must first be defined in ways that are understandable and valuable to others outside of that area of expertise.[210] The chaplain educates physicians and other clinical staff on spiritual, religious, existential, or cultural components that influence beliefs and values, as well as how they can respond as spiritual care givers.[211]

In working together as a team, some factors need to be taken into consideration. Laurenz L. Meier highlights some benefits that come alongside teams. He noted that for teams to be productive, effective, and beneficial, there must be collaboration amongst the members of the team who engage in working together. This is true because lack of collaboration causes work failure, and it is disastrous in hospital because it puts the patient's life at risk. Ideally, such care includes helping patients heal, adjust, recover, cope, and live effectively with disease, illness, and unexpected life changes. Leah states that the goal of MDT in hospitals is to improve patient care, reduce medical errors, and reduce inefficiency. These benefits of an MDT collaboration in health care are paramount because it helps ensure that patients receive the best care. The aim of the team is quality care to all. When there is no clarity concerning the roles and responsibilities of healthcare workers in MDT, it compromises patient care and their safety thereby disrupting collaboration.

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210 John Skanse, *A Chaplain's Expertise: A New Paradigm* (Atlantic Publishing Group, 2017), 27-28.

211 Jerry Nussbaum, *Perinatal grief Coordinator* (Ohio, Columbus: Mount Camel Health system), 35-40.

2.14 Theoretical Foundation

Theoretical foundation is the review of existing theories that serves as a roadmap for your own arguments. Team dynamics are an essential consideration when looking at MDT. Team dynamics can impact the team as a whole and has been identified within the literature as a contributory factor to quality and safety, patient satisfaction, staff satisfaction and overall performance.[212]

2.15 What is a Team?

According to Salas Sims, a team is when two or more individuals with specified roles interacting adaptively, interdependently, and dynamically toward a common and valued goal.[213] Teams are composed of individuals who share a collective identity, common goals, interdependence in terms of assigned tasks or outcomes.[214] Global center gives a clearer definition of health care team, as an MDT profession in which (doctors, nurses, chaplain, social workers, psychologist, dietitian, mental nurse, etc.) professionals from different specialties work together, communicate often, and share resources.[215]

John, Katzenbach, a skilled writer and producer, says that teamwork represents a set of values that encourages behaviors such as listening and constructively responding to opinions expressed by others, giving others the benefit of the doubt, providing support to those who need it, and recognizing the interests and achievements of others. This then implies that teamwork encourages and helps teams succeed, but teamwork alone never

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212 Krista Dawdy, "Merrylee, McGuffin, Collette Fegan: *Understanding team dynamics to promote team building in a radiotherapy department,"* l21,no.1, (September 2020,): 45-50, Doi: 10.1017/S1460396920000813

213 Salas Sims Burke, *"Is there a "Big Five" in Teamwork*?" 36, no. 5 (October 2005): 562, doi:10.1177/1046496405277134.

214 Ryan T. Hartwig and Warren Bird, *Teams That Thrive: Five Disciplines of Collaborative Church Leadership* (Glove Downers, Illinois: InterVarsity, 2015),56-70.

215 HRH, Globa l resource Centre. Why is Teamwork in Health Care Important? https://www.hrhresourcecenter.org.

makes a team unless those team values are incorporated.[216] This statement is true for me because if a group calls themselves a team, they should really be promoting teamwork values. A team works to promote team performance as individuals as well as the performance of the entire organization.[217] Another reason teamwork is important is that clinical care is becoming more complex and specialized, forcing medical staffs to attempt complicated health services and quickly learn new methods. If they cannot function as a team, failure in operations may arise. More so, researchers have found that working together reduces medical errors and increases patient safety by achieving holistic care. Therefore, the team should focus on the achievement of collective results.[218]

2.16. Factors that Lead to MDT Cohesion

Empirical research studies show that healthcare when MDT has team qualities, they will bring serenity. These qualities are clear goals, and role boundaries, communication, leadership, trust, and individual expectations as key themes that contribute to the unity of the team. Jones, Adrian a mental health specialist made a statement in a journal that health professions defend their roles within a MDT setting by asserting their professional responsibilities in the work they do, which may in turn create barriers and conflict through disputes of ownership in some practice areas as well as defining boundaries.[219] Irene, Melinda Netto, a specialist in human resource states that a term that is committed, coordinated, focused, adaptable and has diverse skills and talents

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216 John Katzenbach and Douglas Smith, *The Wisdom of Teams: Creating a High-Performance Organization* (McGraw-Hill,1993), 22-30.

217 Katzenbach and Smith, "The Wisdom of Teams," 22-25.

218 Patrick Lencioni, M. *The Five Dysfunctions of a Team: A Leadership Fable* (John Wiley & Sons, Incorporated, 2002), 11, 190.

219 Jones Adrian, "Multidisciplinary Team Working Collaboration and Conflict. International Journal of Mental Health Nursing," 15, no. 1 (November,2006): 19-30 doi: 10.1016/j.jmpt.2009.10.005.

will definitely succeed.[220] Pat Macmillan, the founder and chief executive officer of team resources clarifies the characteristic of teams as follows.

2.16.1 A common Purpose

Macmillan talks of purpose, which is the single most important ingredient in a team's success. When purpose is not well defined, its breeds confusion and conflict, because team members assigned from different department becomes confused on the team's priorities and why they were sent to that MDT.[221] The power of MDT flows out of the alignment of a purpose.[222] Macmillan cautions that teams are not ends in themselves, but rather means to an end and are ultimately judged by their results. The issues of health are central. Macmillan gives this motivating statement that the diversity of specialties within the modern team makes unity of purpose. critical for purpose does not only calls the team together but, like glue, holds them together. The task of any team is to accomplish an objective and to do so at exceptional levels of performance.[223] I agree with pat that when a healthcare team cannot give quality care, all patients are at risk, because we are dealing with people's' lives. MDT cannot exist for long without a performance driven purpose to justify the team's continuous existence.[224]

2.16.2 Clear Goals

Netto suggests that an MDT that thrives, are those that translate the purpose into a well-defined set of tangible and measurable goals.[225] Goals should include what will be

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220 Netto. Irene Melinda, "Building High Performance Teams and its Sustenance (P.G. College)," https://www.academia.edu/5412092.

221 Katzenbach and Smith, "The Wisdom of Teams," 45.

222 Pat MacMillan, *The Performance Factor: Unlocking the Secrets of Teamwork* (Nashville: Broadman and Holman, 2001),34.

223 MacMillan, *The Performance Factor, 35.*

224 Katzenbach and Smith. *The Wisdom of Teams*, 22-25.

225 Netto, *Building High Performance Teams and its Sustenance*, 3-4.

achieved for the client in terms of performance.[226] Netto noted that team goals become misaligned when priorities of individual team members in the institution are not addressed through flexibility and collaboration, between team members.[227]

2.16.3 Working Approach

Macmillan says that a common working approach is something the team comes up with on its own and has to be unique for each team.[228]This is true of the MDT in a hospital because if synergy is not cultivated, there can be chaos. It is preferable for every MDT member to be present to listen to the lead nurse's report for each shift so that meaningful contributions about the life of the patient can be made.

Macmillan states that every team member must be clear about his or her role, as well as those of the other team members. He continues to say that roles are all about how we design, divide, and deploy the work of the team. When we divide the task well, there is interdependence which makes each team member cooperate. Trust is the biggest factor in choosing to cooperate.[229] Netto echoes that their working approach allows substantive time for creative team thinking and brainstorming. There are clear expectations about the roles played by each team member. When action is taken, clear assignments are made, accepted, and carried out. Work is fairly distributed among the team members.[230]

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226 Netto, *Building High Performance Teams*, 5.

227 Lorne Iwanow Rod, *Exploring Conflict within Multidisciplinary Teams in the Acute from a Nurses Perspective* (Royal Roads University MA Thesis, 2019): 51-53.

228 MacMillan, *The Performance Factor,* 6.

229 MacMillan, *The Performance Factor,* 35.

230 Toler Stan, *Leader-Coach: Developing Effective Ministry Teams* (Kanas: Beackon Hills, 2013), 114-119.

2.16.4 Communication

Macmillan reiterates that communication is the very means of cooperation. Both hospital chaplains and an MDT should have communication skills that are needed to aid dialogue in the team.[231] A team, cannot move faster than it communicates. Fast, clear, accurate communication is a hallmark of elevated levels of team performance.[232] As an MDT, they should note that effective communication is key to thinking collectively and finding synergy in team solutions. Rod Lorne Iwanow confirms that a breakdown in communication is a catalyst for conflict because team members are unwilling to listen in an authentic way to other opinions and instead promote entrenched views of their own.[233] As a result, an MDT must approach communication with a determined intentionality and allowing each member to express themselves.[234] Netto agrees by stating that if communication is made effective within the team, it eliminates confusion and fosters a healthy and happy workplace. This entails team members choosing their words carefully.

Effective communication within the team will allow the work to get done more quickly and efficiently.[235] Clinebell has suggested some essentials for physician-chaplain relationships which are, mutual understanding and appreciation of each other's unique competencies, views, insights, and contributions, willingness to communicate, and be open to learn from each other because nobody is above learning.[236] In the health care system, you can never claim the "Know All Attitude,"[237]

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231 Esquive, *Application of Clinical Ethics*, 35-37.

232 MacMillan, *The Performance Factor*, 38.

233 Iwanow, "Exploring Conflict within Multidisciplinary," 47-48.

234 Iwanow, "Exploring Conflict within Multidisciplinary," 38-39.

235 Netto, *Building High Performance Teams*, 6-7.

236 Kim Kubler, Maller Davis, and Crystal Dea Moore, *Palliative Practices: An Interdisciplinary Approach* (Saratoga Springs, NY: Elsevier Mosby, 2005), 15.

237 Clinebell, *Healing and Wholeness*, 11-18.

2.16.5 Team Processes

Macmillan came up with team processes as a factor for a successful MDT. He says that teams should identify, map, and then master their key team and organizational processes.[238]A surgical crew in the theatre cannot just wake up and start doing surgery blindly, but must have discussed line of action. They constantly evaluate the effectiveness of key processes, asking: How and what are we doing? What are we learning? How can we do it better?[239]

2.16.6 Solid Relationships

Macmillan says that solid relationships are vital in MDT. Solid relationships involve respect for one another, mutual trust, commitment, acceptance, courtesy, and a liberal dose of understanding. Clinebell concords that honest communication brings solid relationships.[240]

2.16.7 Creating Good Rapport and active listening among team members is essential.[241]

Good teams are diverse in skill, experience, and knowledge. This diversity is needed to divide the task effectively and creatively.

Macmillan states that the more different a team is, the smarter it can be.[242] On the MDT we have Physician, chaplain, social worker nurse, pharmacist, and physiotherapist. They relate well for the good of the patients. With this diversity and expertise, they surround and investigate problems, diagnosis with a brighter IQ. Iwanow confirms that a lack of mutual respect between individuals can create relational conflict within MDT. But

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238 MacMillan, *The Performance Factor*, 37.
239 MacMillan, *The Performance Factor*, 37-38.
240 Clinebell, *Healing and Wholeness*, 115-116.
241 Kubler, Davis, and Moore, *Practices: An Interdisciplinary Approach*, 32-35.
242 Kubler, Davis, and Moore, *Practices: An Interdisciplinary Approach*, 37, 49.

when the team chooses to enhance interpersonal and professional relationships through mutual respect and the valuing of member's contributions to the team, it will reduce the conflict.[243]

Patrick, Lencioni noted in his leadership model that members of a team come on board with different temperament and personality disorders that need urgent intervention and treatment or else the institution risked collapsing.[244] Patrick observes that as difficult as it is to build a cohesive team, it is not complicated. In his model, he gives us five dysfunctions of a team as well as five strengths of a team. Pat clearly states the five dysfunctions which are:

1) **Absence of Trust Among Members**. This stems from their unwillingness to be vulnerable within the group. Team members who are not genuinely open with one another about their mistakes and weaknesses make it impossible to build a foundation for trust. This failure to build trust is damaging. Trust is crucial for teamwork to flow.[245] Pat says that If team members do not trust you, it is likely that they will not be dependent on you to achieve their goals and interests. Trust glues a team together.[246]

2) Fear of conflict. Teams that lack trust are incapable of engaging in un- filtered and enthusiastic debates of ideas. Instead, they resort to veiled discussions. If a team is not having healthy disagreement, then it means people are not free to share ideas or their view on issues. One should be able to vent ideas without his personality being attacked. In MDT we should learn to attack processes and not persons or personalities.[247]

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243 Iwanow, *Exploring Conflict within Multidisciplinary Teams*, 55.
244 Lencioni, *The Five Dysfunctions of a Team*, 37.
245 Lencioni, *The Five Dysfunctions of a Team*, 188.
246 MacMillan, *The Performance Factor*, 36.
247 Lencioni, *The Five Dysfunctions of a Team*, 189.

3) **Lack of Commitment**. Without having aired their opinions during enthusiastic and open debate, team members rarely buy in and commit themselves to decisions, though they may agree during meetings but will be passive to commit themselves.[248]

4) **Avoidance of Accountability** In accountability, everyone takes responsibility for their activities, decisions, and outcomes. Without committing to a clear plan of action, even the most focused and driven people often hesitate to call their peers on actions and behaviors that seem counterproductive to the good of the team. Accountability is crucial when someone feels a sense of belonging and ownership. If not, they become passive and will not care how the company ends up.

5) **Failure to Hold One Another Accountable Creates an Environment for poor results**. Inattention to results occurs when team members put their individual needs (such as ego, career development, or recognition, title, or position) above the collective goals of the team. Another way Patrick describes the qualities of a cohesive team are:

They trust one another.

They engage in unfiltered conflict around ideas.

They commit to decisions and plans of action.

They hold one another accountable for delivering against those plans.

They focus on the achievement of collective results.

Patrick observes that if this sounds simple, it is because it is in theory. In practice, however, it is extremely difficult because it requires levels of discipline and persistence that few teams can muster.[249]

Researchers have identified some gaps hindering an MDT from reaching its full potential which include differences in training and approach to problem solving. Health care team should collaborate with chaplains so that the delivery of spiritual care can also

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248 Lencioni, *The Five Dysfunctions of a Team,* 189-190.

249 Lencioni, *The Five Dysfunctions of a Team*,190.

be achieved in the team.[250] More so, each team member is unique in their personality and values which affect the team from reaching their goals if not managed.

2.17 Gaps on the Part of the Chaplain in the MDT

Chaplain as members of the MDT, have made some mistakes, thus some difficulties set in, and obscured their ministry in the hospital.

According to George chaplains are increasingly seen as key members of MDT yet what chaplains specifically do in terms of assessments, hoped for outcomes, and interventions remains poorly understood.[251] This is a major setback on the chaplains.

Chaplains lack a consistent way to describe their activities. Attempts have been made to develop inventories of chaplain activities and propose standard terminologies, yet none of these attempts were empirically based and none of these attempts have emerged as normative.[252]Therefore chaplains should close this gap on the team. If other members do not see you accessing documents or pen down something somewhere, how are they going to believe you did it or it was mere imagination. Their work sometimes cannot be captured or measured, giving them a poor perception.

Loewy, Springer, and Loewy, Erich say that chaplains do not have the needed skills or training that is required to for them to be in the different committees of the hospitals. Hospitals are increasingly finding it beneficial to have chaplaincy representation on several committees dealing with issues such as ethics, palliative care, and customer service.[253] This sometimes have put their competence into questioning.

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250 Larry Vandecreek, Harworth. *Ministry of Hospital Chaplains: Patient Satisfaction* (NY: Haworth Pastoral, 1997), 22-24.

251 Fitchette et al., *Evidence-Based Healthcare Chaplaincy,* 69.

252 Fitchette et al., *Evidence-Based Healthcare Chaplaincy*,70.

253 Loewy Springer, and Loewy Erich, "Healthcare, and the hospital chaplain," *Medscape General Medicine*, 9 no. 1 (May 2018): 5. http://www.medscape.com/viewarticle/552447.

George explains that chaplains perform a variety of interventions with a therapeutic intent yet lack a unified and consistent naming set for these interventions which would better portray to the MDT what goals and results they strive to achieve.[254] An article titled health care chaplains: finding meaning and comfort states that lack of accepted outcomes, methods, and instruments for measuring spiritual care and its effectiveness will inevitably mean that the spiritual domain will not be included in general health care research.[255] He proposes that a classification could be used to enhance an MDT understanding of the chaplaincy work.[256]This taxonomy or classification will form the basis for clinical documentation which could be set to standardize descriptions chaplains share about their spiritual care to patients, families, and staff.[257]

The lack of evidence-based research in chaplaincy has led to a call to chaplains to engage in research. The process of moving to a research-informed practice is minimal in spiritual care.[258] Without research, spiritual and religious issues will continue to be neglected in the care of the patient and family.[259]

Fitchett suggested that another barrier could be competing interest amongst MDT and chaplains. Even though most chaplains deny that they are not into competition, it can create a gap for them in the MDT if some are doing so.[260] Holst, states that the tension and collision between the chaplains and the health care team is the because of the ceaseless cravings for control.[261] As chaplains, while striving to place value on your

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254 Fitchette et., al., *Evidence-Based Healthcare Chaplaincy*, 75.

255 *Testing the Efficacy of Chaplaincy Care*: *Health care chaplains, Finding meaning and Comfort*. https://healthcarechaplaincy.org.

256Fitchette et al., *Evidence-Based Healthcare Chaplaincy*, 76.

257 Fitchette et al., *Evidence-Based Healthcare Chaplaincy*,78.

258 O'Connor T. and Meakes, "Hope during challenge: Evidence-based pastoral care," *Journal of Pastoral Care*, 5, 2no. 4, (1998): 359 -367, doi: 10.1177/002234099805200405.

259 Berlinger N, *The nature of chaplaincy and the goals of QI: Patient-centered care as professional responsibility,"* 38, no. 6 (2008), 29- 40, https://doi.org/10.1353/hcr.0.0083.

260 Fitchette et al., *Evidence-Based Healthcare Chaplaincy,* 82.

261 Holst, *Hospital Ministry*, 4.

ministry, be mindful of the fact that there is a team and a team lead who is the doctor. Complement and push your concerns healthily.

2.18 Educational Requirements for a Hospital Chaplain

Christina states that hospital chaplains are trained and certified to work in health care institutions with patients, care givers and staff [262]Chaplaincy grew as a profession through the development of standards of practice, certification, and training, establishing itself beyond traditional settings.

In 1940, Russell Dicks was the first to develop and propose standards for professional chaplains. Over several decades, the standards of practice for professional chaplains evolved, but still reflect the chaplain's responsibility to the hospital and care of the patients. The 1920s marked the beginning of CPE. It is an experiential theological education process which helps a chaplain to gain self-awareness about himself. It also helps the chaplain to integrate theological insight into his pastoral care. CPE grew out of the intensive discussions early in the twentieth century that examined the value and efficacy of America's medical and theological educational institutions. After twenty years of consultation, the Council of Clinical Training, the Institute of Pastoral Care, the Southern Baptist Association for Clinical Pastoral Education, and the Lutheran Advisory Council on Pastoral Care merged in 1967 into the Association of Clinical Pastoral Education, Inc. This new association became the standard-setting, accrediting, and the certifying body for the clinical theological education of students. CPE places the hospital chaplain in actual ministry situations where he encounters people and the God. With the theological and CPE education that the chaplain has acquired, he is competent and is able to integrate spiritual perspectives into his pastoral care in the hospital.[263]

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262 Puchalski and Ferrell, *Making Health Care Whole: Integrating Spirituality into Patient Care* (England: Templeton, 2010), 61.

263 Roberts, *Professional spiritual and Pastoral care,* 40-45.

In a more personal way, CPE gave me an awareness of who I am, as I did self-reflections by integrating spiritual insight into pastoral care as I go to minister a chaplain. This is because each person is unique in God's agenda. CPE is a method of professional education, and it is governed by a set of standards that ensure that every program works the same.[264] Each program has component parts centered on the learning contract, didactics, verbatim studies interpersonal group, professional readings, and individual supervision.[265]

CPE brings theological students and ministers of all faiths (pastors, priests, rabbis,) into supervised encounters with persons in crises.[266] CPE units are accredited in hospital institutions through their certifying organizations. In North America, chaplains are certified by at least one of the national organizations that are recognized by The Joint Commission for Accreditation of Pastoral Services.[267] The Association of Professional Chaplains (Canadian Association for Pastoral Practice and Education (approximately 1,000 members), National Association of Catholic Chaplains (approximately 4,000 members), and the National Association of Jewish Chaplains (approximately 400 members)

Dawn states that Board Certified chaplains are required to have a theological education and significant supervised clinical training (CPE).[268] In order to fulfill the requirements of a board-certified professional chaplain, a chaplain must have obtained a seminary degree and has undergo a basic unit in CPE. The preparation requirement for a chaplain is two sequential units above the basic level followed by an advanced level as

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264 N*ational Conference on Clinical Pastoral Education. Trends in clinical pastoral education : objectives, methods, and standards* (Washington, D.C. 1960), 4-10.

265 Puchalski and Ferrell, *Making Health care Whole* 160-161.

265 Belgum, *Clinical Training for Pastoral Care*, 11.

266 Belgum, *Clinical Training for Pastoral Care*, 11.

267 Puchalski and Ferrell, *Making Health Care*, 160.

time goes on.[269] CPE units typically involve 400 hours, in which chaplain interns participate in caregiving ministry in the hospital and are supervised.[270] CPE seeks to develop the capacity of the chaplain to step back from preconceived notions and see the plan in the other person's life unfolding; that is where they are and where they might be going in their growth. There is explicit training in ethical behavior and experiential training in self-reflection, reflective listening, and learning through engaging and with other humans. This CPE has produced some meaningful changes in the way chaplain minsters. As a result, students show positive change in counseling resources, facilitative relations, and non-judgmental acceptance. The program emphasizes a people-centered approach to spiritual ministry. Here learning occurs through direct ministry experience, use of reflective tools, didactic seminars, dialogue, and individual supervision.

2.18.1 Chaplaincy Certification

The Association of Spiritual Care announces that the process of chaplains' certification is governed by Common Standards for Certification adopted by the leading professional chaplaincy Associations in North America. This standard requires a master's level degree in theology or a related field, endorsement by a religious community. It goes with an in-depth interview by a peer review committee.[271] This Association of Spiritual Care states that, CPE is a process model of education, predicated on students' individual needs that are compatible with program objectives. Thus, certification standards define the professionalization of chaplains in health care. When there are standards of practice, it helps chaplains communicate with other disciplines, and the society what types of services we should expect from professional chaplains.

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[269] Dawn and Schipani, *Spiritual Care in the Hospital*, 23.

[270] Dawn and Schipani, *Spiritual Care in the Hospital*, 22

[271] "The Spiritual Care Association- chaplaincy network*," October 2020*. https://spiritualcareassociation.org.

2.19 Conclusion

The literature review centered on the perception of the role of the of hospital chaplain in the MDT in the Cameroon Baptist Convention. The literature review provided current literature relevant to the topic. This was developed through major themes like hospital chaplains, misconceptions, the value of, ministry of presence MDT, and the role of the chaplain, factors that promote teams, educational standard, and certification for chaplains. Holistic care to patients captured their physical, social, emotional psychological and spiritual dimensions. While several studies have been done on the role of chaplains, little is said about how the MDT perceives the role of the chaplain. It is one thing to know someone's role but it's another thing to utilize and value it. When all these components are fully maximized, it gives satisfaction to patients. Neglect of any one's role will cause threats to patients` lives and can prolong their healing. When the chaplains are not used, spiritual care will be left out of the health care equation. The efficacy of chaplaincy care is beginning to grow. It is in an embryonic state, but methodologies prefer that interventions, and desired outcomes be documented and developed. Much needs to be done to describe the current state of who chaplains are, where they work, and what they do to dismiss the oblique and distorted impression and perceptions concerning them.

CHAPTER 3

BIBLICAL AND THEOLOGICAL FOUNDATION

3.1 Introduction

Even though the word chaplain is not in the Bible, the idea of who and what a chaplain is and what he does is saturated in Scripture. The role of the chaplain is to complement the multidisciplinary team so that holistic care can be achieved. The chaplain as a pastoral care giver in the hospital stands with the vulnerable to speak justice, shows compassion, mercy, care, instills hope, ministers healing to the sick, emotionally distressed ones, the broken hearted, and the depressed through the word of God. His presence with the patients and caregivers validates the presence of God as he represents God before the patients. From the Bible sickness is a reality, and it will continue to be real if we are in this mortal bodies. Scripture consistently teaches this from Genesis to Revelation.

Visitation to a hospital patient's bedside appeals to the chaplain as a fruitful and rewarding Christian service. A sincere desire to support and comfort an ill patient, bringing hope and encouragement stirs up the faith of the patient. (psalms41:3, 1Corinthians1:3-5, Matthew 11:28, 1John1:2). Holistic healing is a fundamental dimension of religion. The Bible clearly states that those who suffered from infirmities and afflictions (sicknesses, pain, anxiety, grief worries) received their healing through the different methods scriptures uses.

The chaplain's healing ministry is ground in Scriptures which states that God comforts us in every trouble so that we may also be able to comfort (Love, care) those who are in trouble or distress, with the comfort with which we have received from God (2Corinthians1:4). Russel L. Dicks who was a chaplain says that hospital chaplain relates these Biblical passages to the sick, to those who are psychologically tortured, the emotional, psychosomatic patients through prayers, encouragements, and the laying of hands.[272] The chaplain uses the Bible as one of his tools to pray for the sick, instills hope to the hopeless, peace to the restless and direction to those who are confused with their diagnosis.[273]

3.2 The Old Testament Basis for Healing

3.2.1. Biblical Foundation

The Bible makes it clear that sicknesses came because of the fall.[274] It was because of the disobedience of Adam and Eve in the Garden of Eden. God created man in his own image, in the image of God he created him male and female (Genesis1:27). The plan of God did not include sickness, affliction, pain, or death. Man's disobedience not only brought sin, but it opened the door for sickness and death. Christ redeemed us from the curse when he died on the cross. Jesus took our infirmities and carried our sorrows. By his wounds, we are healed (Isaiah 53:4-5). This passage refers to both physical and spiritual healing that Christ purchased for us.[275]

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[272] Richard Clarke and Russell L. Dicks, *The Art of Ministering to the Sick* (New York: Macmillan, 1999), 234-235.

[273] Clarke and Dicks, *The Art of Ministering to the Sick*, 234.

[274] Don Stewart, *According to the Bible, Why Do People Get Sick*? https://www.blueletterbible.org

[275] Grudem, *Systematic Theology*, 1063-1068.

Physical, spiritual, and emotional illnesses are recorded in the Old Testament. Healing has to do with body, soul, or spirit. God speaks of being close to the broken hearted (Psalms 34:17-19). When God heals, he makes the person also renewed and whole. This is the pastoral care that a chaplain does. Making sure the patient who entered the hospital leaves the hospital being cared for.

In the Old Testament, God made some statements about who He is in relation to illness and affliction people go through. He is the healer, close to the afflicted, defends the defenseless and delivers his people.

Exodus 3:6-9 (NKJV) And the Lord said to Moses, I have surely seen the affliction of my people that are in Egypt, and I have heard the cry caused by their taskmasters; for I know and have seen their affliction. Matthew Henry observed three things God took notice of in Israel's affliction, He knows and sees, their cry, and their sorrows. As a healer of affliction, God employs pastoral care giving skill by coming down to deliver them.[276]

Psalms 34:18-19 (NKJV) The eyes of the Lord are on the righteous, And His ears are open to their cry. The face of the Lord is against those who do evil, to cut off the remembrance of them from the earth. The righteous cry out, and the Lord hears, and delivers them out of all their troubles. The Lord is near to those who have a broken heart and saves those with a contrite spirit. Many are the afflictions of the righteous, but the Lord delivers them out of it. Affliction here can be spiritual sicknesses, emotional pain, psychological, disease, plague, or infirmity.

Exodus 15:26 (NKJV) God said to Israel I Am the Lord, Your Healer and if you diligently heed to the voice of the Lord your God and do what is right in His sight, give ear to His commandments and keep all His statutes, I will put none of the diseases on you

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[276] Henry Matthew, *Commentary on the Whole Bible: Complete and Abridged in One Volume* (Nashville, Tenn: Thomas Nelson, 1997), 98-99.

which I have brought on the Egyptians. The Hebrew word for God in Exodus 15:26 means the healing one which can be legitimately translated, I am the Lord, your healer (RSV), I am the Lord who heals you (NKJV), or I am the Lord, your physician.[277]

3.3 Types of Illnesses in the OT

3.3.1 Physical Sicknesses in the Old Testament

In 2kings 20:1-6 (NKJV), a prophetic word came to Hezekiah saying thus says the Lord: Set your house in order, for you shall die, and not live. Hezekiah was sick and near death. And Isaiah the prophet, the son of Amoz, went to him and said to him, "Then he turned his face toward the wall, and prayed to the Lord, saying. Remember now, O Lord, I pray, how I have walked before You in truth and with a loyal heart and have done what was good in Your sight. And Hezekiah wept bitterly. And it happened, before Isaiah had gone out into the middle court, that the word of the Lord came to him, saying, return and tell Hezekiah the leader of My people, thus says the Lord, the God of David your father: I have heard your prayer, I have seen your tears, surely, I will heal you. On the third day you shall go up to the house of the Lord. And I will add to your days fifteen years. I will deliver you and this city from the hand of the king of Assyria; and I will defend this city for My own sake, and for the sake of My servant David.

Theologically, when a messenger or prophet came with words like in "Thus says the Lord," it was understood as a standard formula implying the words were directly from God and undisputed. The prophet only cited God's words as God used them as mouthpiece.[278] The surprising thing is that Hezekiah did not take this as the last word. The Bible recounts that Hezekiah turned his face toward the wall and wept bitterly. God,

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[277] Gaiser Frederick, *Healing in the Bible* (Grand Rapids, MI: Baker, 2010), 21-25.
[278] Gaiser*, Healing in the Bible*, 50-55.

being a compassionate God, heard him. As the chaplain moves into the ward, he has the Bible as his tool to encourage patients, families, and staff that God takes human suffering seriously. He answers prayers. God heard the weeping of the of the psalmist in Psalm 6:8 he testified that; "Depart from me, all you workers of iniquity, for the Lord has heard the voice of my weeping. The Lord has heard my supplication. This is verifiable also in Exodus 2:23, 3:7 (NKJV), where God heard the cry and the groaning of the Israelites. It was not merely Hezekiah's prayer, but his words, his silent tears which God said that He heard and had seen his tears. [279]The tears of the faithful are precious to God that they are captured by God. In 2 kings 20:5 (NKJV), God declared, that He will heal Hezekiah. When God announces judgment, it is always an invitation to repent and to receive mercy.[280] This story shows us that the conversation of prayer is real. The chaplain moves with these scriptures in his heart for the sick which brings consolation to them. God had determined that Hezekiah would die, but in response to Hezekiah's prayer, God granted healing. As chaplains work with those who are ill, they pray with the patients, relates these stories of the Bible, and instills hope to the patient. This does not mean that our healing is dependent on our prayer, whether we pray correctly or pray enough. That would make healing our work rather than God's work. The text says, "I will heal you." God choses to heal whom he heals. It is God's will not ours. God honors prayers.[281]

Ps.56:8 (NKJV**)** You keep track of all my sorrows. You have collected all my tears in your bottle. You have recorded each one in your book. You have kept track of my every toss and turn through the sleepless nights, each tear entered in your ledger, each ache written in your book. The hospital chaplains put back these words of Scriptures to

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279 Gerald Calhoun, *Pastoral Companionship: Ministry with seriously ill Persons and Their families* (New York: Paulish, 2005), 57-70.

281 *Henry Matthew's commentary*,552-553.

the patients who are passing through similar situations so that they will understand that God knows all what they are going through, and he has captured their tears in His bottles.

3.4 Mental Illness in the Bible

The Mirriam Webster dictionary defines mental illness as a broad range of medical conditions (such as major depression, schizophrenia, obsessive compulsive disorder, or panic disorder) that are marked primarily by sufficient disorganization of personality, mind, or emotions to impair normal psychological functioning and cause marked distress or disability and that are typically associated with a disruption in normal thinking, feeling, mood, behavior, interpersonal interactions, or daily functioning.[282]

People can commit suicide when they are depressed.[283] Whenever someone is depressed, his reasoning is blocked, he lacks the capacity to find a solution because he is depressed to think about a solution. God knows more about depression, anxiety, despair, and sadness more than anyone else in this world-any psychiatrist, counselor, pastor, or friend.

Depression ranges in seriousness from mild, temporary episodes of sadness to severe, persistent depression or chronic. Clinical depression is the more-severe form of depression, also known as major depression or major depressive disorder. It is different from depression caused by a loss, such as the death of a loved one, or a medical condition. Symptoms are usually severe enough to cause noticeable problems in relationships with others or in day-to-day activities, such as work, social activities.[284]

Situational depression is a short-term, stress-related type of depression. It can develop after one experience a traumatic event or series of events. Situational depression

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[282] Webster Mirriam, May 5,2024. https://www.merriam-webster.com.

[283] Vanora Leigh, *Mental Illness* (East Sussex, England: Way Land, 1998), 4-10.

[284] Patricia Benner and Judith Wrubel, *The primacy of Caring: Stress and Coping in Health and Illness* (Menlo Park, California: Wesley, 1989), 208-209.

is a type of adjustment disorder. It can make it hard for you to adjust to your everyday life following a traumatic event like illness or the loss of a loved one. It is also known as reactive depression.[285]

3.4.1 Symptoms of Mental Illness

Symptoms of clinical depression and mental illnesses can range from mild to severe, but they typically will last for weeks before a diagnosis is made.[286] It can be a loss of interest in activities that once brought joy, trouble sleeping (insomnia), low energy or fatigue, feeling worthless or excessively guilty, decreased concentration, thoughts of death or suicide, stressed, feelings of anger, and change in eating patterns.[287] At this juncture, the chaplain comes in to care for the mind that has been distorted by helping them find meaning and purpose in life.

Depression was diagnosed in Elijah as he uttered words indicating his distressful condition**.** It is a psychiatric condition.[288] In 1Kings19:1-4 (NKJV), Elijah fled from Jezebel when Jezebel sent a messenger to Elijah, saying, "So let the gods do *to me,* and more also, if I do not make your life as the life of one of them by tomorrow about this time. Elijah cried to God saying "I have had enough, Lord. Take my life; I am no better than my ancestors. These words were spoken from a depressive heart. Elijah was discouraged, weary, and afraid. Ahab told Jezebel all that Elijah had done, also how he had executed all the prophets with the sword. Then Jezebel sent a messenger to Elijah, saying, "So let the gods do to me*,* and more also, if I do not make your life as the life of one of them by tomorrow about this time. Elijah was worn down, broken down and

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[285] Benner and Wrubel, *The primacy of Caring*, 208-209.

[286] Wicks et al*., Clinical Handbook*, 269.

[287] Jane Bingham, *Emotional health Issues: stress and depression* (UK: Wayland, Hachette, 2010), 3-15.

[288] Wicks et al., *Clinical handbook of Pastoral Care,* 9, 468-470.

depressed. God showed compassion and gave him food and sleep.[289] Depressed patients are anxious and suffer from insomnia. Questions like "God why me, let me die," are indicators of depression. Paul, Enenche, a medical doctor, and pastor said that depression is a long-term state of mind characterized with extreme unhappiness and inability to visualize a happy future. It is a powerfully negative mood that interferes with daily life. Depression is more than sadness. Depressed people feel sad, empty, despondent, disinterested, and lethargic. Depression is a major destroyer of life and destiny. It is a major sponsor of oppression. Suicidal tendencies are higher in depressed people.[290]

3.4.2 Scriptural Solution to Depression

Proverbs17: 22 (NKJV), A happy heart is good medicine, but a crushed spirit dries up the bones.

Psalm42:11 (NKJV) Why are you downcast, O my soul? Why so disturbed within me? Put your hope in God for I will yet praise him, my Savior, and my God. David's story is filled with mental anguish and struggle that stem from depression. In many of the Psalms, he writes of his anguish, loneliness, fear of the enemy, his heart-cry over sin, and the guilt he struggled with because of it. We also see his huge grief in the loss of his sons.

Psalm 49:19 (NKJV), David testified that when his anxiety was huge within him, God's consolation brought him joy.

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[289] Andy Davis, "The Life of Elijah," July 21, 2002, https://twojourneys.org.

[290] Paul Enenche, *Seed of Destiny: The Cure for Depression* (Abuja, Nigeria: Dunamis, 2018), 1-2.

3.5The NT Teachings on Healing

3.5.1 Jesus' Healing Ministry

One of Jesus's names which is used in Christendom is, "The Great Physician." This is seen in (Mark 2:17 NKJV). This name is more instructive for us today. Jeus was not only concerned with the spiritual condition of those he ministered to, but also with their emotional, psychological, mental, and physical state. His ministry was holistic in nature. It involved completeness and a total transformation of spirit, mind, and body. The domains His healing could be:

1. **Spiritual healing**. This restores our relationship with God. This is always Jesus' priority in healing ministry.
2. **Inner healing** brings restoration from the wounded effects of our own sin. This brings forgiveness and reconciliation into our relationships.
3. **Physical healing**. It gives us a foretaste of the resurrection power of Jesus Christ in our bodies being restored to complete health.

3.5.2 Scriptural Passages of Jesus' Healing Ministry

Matthew 9:35–38 (NKJV) Then Jesus went about all the cities and villages, teaching in their synagogues, preaching the gospel of the kingdom, and healing every sickness and every disease among the people. But when He saw the multitudes, He was moved with compassion for them, because they were weary and scattered, like sheep having no shepherd.

Mark 1:41-42 (NKJV) Then Jesus, moved with compassion, stretched out His hand and touched him, and said to him, "I am willing; be cleansed." As soon as He had spoken, immediately the leprosy left him, and he was cleansed.

Luke 5:31-31 (KJV) Jesus answered and said to them, "Those who are well have no need of a physician, but those who are sick. The sickness referred to by Jesus here is understood to be a physical or a spiritual disease. Here, Jesus has used a physician as an example of one who restores the sick. All the four Gospels reveal that He healed many.

Matthew4:23-24 (NKJV), Jesus went about all Galilee, teaching in their synagogues, preaching the gospel of the kingdom, and healing all kinds of sickness and all kinds of disease among the people. Then his fame went throughout all Syria; and they brought Him all sick people who were afflicted with various diseases and torments, and those who were demon-possessed, epileptic people, and paralytics; and He healed them**.**

Luke 4:18 (NKJV), Jesus declares his mission that the Spirit of the LORD is upon Me, because He has anointed Me, to preach the Gospel to the poor; He has sent Me to heal the brokenhearted, to proclaim liberty to the captives and recovery of sight to the blind, to set at liberty those who are oppressed, to proclaim the acceptable year of the LORD.

The gifts of healing are among the spiritual gifts listed in 1 Corinthians 1:1-14. This gift is still available to the church today. In 1corinthians 12:7, Paul says that this healing gift is given for the common good of the church.

In Matthew 25:35-36 (NKJV), I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me. Here, Jesus is defining hospital ministry and spiritual care in practical terms by giving people food, water, shelter, and clothing. Jesus understood that unless their basic survival needs are met, the people will not listen to the spiritual needs which is their real needs. Ministry is surrounded by helping those who need help. Jesus' ministry displayed a caring for those who were vulnerable, rejected, and isolated and poor. Throughout His lifetime, Jesus ministered to those most in need as an example for

chaplains and Christians to follow.[291] The chaplain should always exercise wisdom in choosing the appropriate ministry intervention for each situation and the Gospel will be preached after meeting their basic needs. Jesus made ministry practical in-order to make evangelism possible.[292]

The question is, does the healing gift still valid and available today, or it ended with the Apostles. This question has brought a lot of debate in the church today. Some people have argued that some miraculous gift like prophecy, speaking in tongues, and the gift of healing ended with the Apostles. To some Christians, some gifts were more than some 1corinthians (14:1-5 NIV) these gifts were meant for the edification of the church.[293]

The cessationists assert that the miraculous gifts such as prophecy, healing, and speaking in tongues ceased with the apostles.[294] To the cessationists, they believe that these gifts were a "sign" to authenticate the Apostles during the preaching the gospel in the Apostolic age and no longer needed today.[295] In general, non -cessationists hold that all NT spiritual gifts have remained operative, even until today.

The healing ministry that existed in the times of Jesus Christ, the Apostles, and the early church is still available today. The church is a part of the New Covenant with better promises which include healing.[296] In Mark 16:17-18 (NIV), And these signs will accompany those who believe: In my name they will place their hands on sick people, and they will get well. In James 5:15 (NIV), And the prayer offered in faith will make the sick person well. It is worth noting that not all prayers for healing will be answered in this

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[291] Jeffries, "The Role and Function of a Hospital Chaplain," 50-55.

[292] Paget and McCormack, *The Work of the Chaplain*, 7-8.

[293] Feferick F. Bruce, *The International Bible Commentary* (New York, 1986), 1370-1380.

[294] Leon Morris, *Tyndale New Testament commentaries* (Grand Rapids, MI: Eerdmans, 1990), 170-180.

[295] Grudem, *Systematic Theology*, 1030.

[296] Grudem, *Systematic Theology*, 1063.

age. But we are confident that God works for the good of those who love Him and are called according to his purpose Romans8:28).

3.6 Purposes of Healing

Christ's healing ministry served various purposes. All of them primarily contributed to the authentication of the person of Jesus as the true Messiah, that men might believe that Jesus is Lord.[297] (John 20:30 NKJV), that the works of God might be displayed in Christ (John 9:3NKJV).It authenticated the gospel message. The healing miracles were never performed merely for their physical benefit but for God to be glorified as people see evidence of His love, goodness, and power.

3.7 The Theological Foundation of Jesus' Healing Ministry

Richard L. Mayhue, Professor of theology and Pastoral ministries says that Jesus used a variety of methods to heal. Jesus did not perform healing indiscriminately, nor did He always heal everyone who needed healing. He knew what to do at a given time. To some, He spat on the ground and made clay with the saliva; and He anointed the eyes of the blind man with the clay. (John 9:6 NKJV), Christ spoke (Matt 9:6-7 NKJV), The afflicted touched Christ's cloak Matt 9:20-22 (NKJV), He touched (Matt 8:15 NKJV), and Jeus spoke (Matt 9:6-7).[298]

In Matt 9:12 Jesus says that- "it is not those who are healthy who need a physician, but those who are ill." He acknowledges and approves of the work of a doctor. David Stevens, Gregg, a medical doctor who has served in Kenya expatriates the Great Physicians' work into the different specialty of the hospital as follows.

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[297] Grudem, *Systematic Theology*,1065.

[298] Richard L. Mayhue, "Cessationism, 'The Gifts of Healings,' and Divine Healing" (Master's Seminary Journal 6, no. 2 (Fall 1995): 15-20.

- The orthopedist knows Jesus was a fellow orthopod. He made the lame to walk and the "bowed" to stand straight (Luke 11:11-13).
- The internist notes that He healed people with heart failure (dropsy) (Luke 13:2-4).
- The ophthalmologist counters, "Don't forget He made the blind to see" (Luke 18:35-43).
- A neurologist points out that Jesus cured a man with palsy (Luke 15:18-25).
- The ENT (ear-nose-throat) specialist reminds us that He caused the deaf to hear (Luke 7:22).
- The infectious-disease specialist declares, "He cured leprosy!" (Luke 5:12-14; 17:11-19).
- The pediatrician quotes Jesus Himself who said, "Let the little children come to me" (Luke 18:6).[299]

All what Jesus did was a prove that the sick ones were vulnerable, and they stood in need of care. All these groups of people are in the hospital waiting for the chaplain to minister to them through their compassionate, listening, loving, empathic, and caring attitude. Jesus remains a model for the chaplaincy ministry. Jesus touched those who were sick both physically and spiritually. He touched the leper (Mark 1:41), laid hands on the blind man (Mark 8:22) and took the hand of the daughter of Jairus (Luke 8:54). Why did Jesus' touch people? Could He not have simply healed them with a word? He touched people to connect with them-one on one, to demonstrate His love, compassion, mercy, and tenderness.[300]

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[299] David Steven, *Jeus M.D.: A Doctor Examines a Great Physician* (Grand Rapids, MI: Zondervan, 2001), 5-10.

[300] Harold J. Sala, *What You Need to Know about Healing: A Physical and Spiritual Guide* (Nashville, Ten: B$H, 2013), 80-82.

As hospital chaplain touch that is appropriate is consoling to the patients. It's therapeutic and a sign of acceptance. A healthy touch is welcome and necessary for patients to thrive and be hopeful.[301] Federick, Gaiser states that touch is not limited to physical contacts only, but more profoundly, personal interaction, emotional sharing, and mutual understanding. Jesus also challenged the social systems and the pharisees as he brought back the outcast into the community. He fought for the vulnerable. He healed people with leprosy whose illness brought them isolation, social discrimination, quarantined, took away stigmatization and integrated them back into the community.[302] The healing power of Christ often comes as comfort and consolation, helping us face our trials with courage [303]

3.8 Jesus, the Theological Model for the chaplains

Kirkwood has put forth a theological model which acts as a tool for chaplains to follow and do theological reflections as they minister to patients, families, and staff. According to Neville, Jesus remains our theological model. He highlights that theology provides the criteria whereby each situation is assessed, and action is taken. It determines the attitude the chaplain should have toward the patient, likewise the state of the patient. If a theology of pastoral care is to have any real validity, the ministry of a chaplain, it should find its roots in the person and work of Jesus Christ. Peter in 1 Peter 2:1 tells us that Jesus, by his own suffering, set the example as to how to cope with the suffering of persecution. Jesus the model reflected the following attributes as He ministered.

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[301] Gaiser, *The International Bible Commentary*, 165-67.

[302] Alvin, Lloyd Maragh, "The Healing Ministry of Jesus as Recorded in the Synoptic Gospels" (PhD diss., Loma Linda University, June 2006), 7-9.

[303] Keith A. Evans, "Pastoral Care in Public Settings: A Theoretical and Theological Premise with Effective Outcomes of Chaplaincy," *Testamentum Imperium* no. l5 (2018): 6-10.

3.8.1 Theology of Love

Love and empathy should characterize the ministry of a chaplain. Brene' Brown a university professor in Houston, says that we cultivate love when we allow our vulnerability to be deeply seen and known, and when we honor spiritual connections that grows from that offering of trust, respect, kindness, and affection.[304] Doing it out of duty removes the warmth and integrity that goes with pastoral care. Love is not something that we give or get but it is something that we nurture. The ministry of Jesus was a continuous display of love and compassion. Disrespect of patients, blame or withholding affection damages the roots from which love grows.[305] The healings, the teachings, the acceptance of gross injustice and humiliation, and the infinite patience were all demonstrations of his great love[306]. LaRocca-Pitts wisely speaks that the wellspring from which all our care arises is love.[307]

3.8.2 Theology of Availability

Jesus, despite the circumstances, made himself available to the people, who had physical, medical, and spiritual needs. That availability is seen when he was moving along with a great crowd of people, healing, and teaching. Jairus, the ruler of the synagogue, sought Jesus' assistance to heal his ailing daughter. Jesus could have said that he was too busy healing scores of people, but He made himself available.[308] He was available even to the insignificant members of society (Mark 5:22-43). When the disciples tried to prevent mothers bringing their children for Jesus to bless. He stopped his teaching, took these children in his arms, and blessed them (Mark 10:13-16).

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[304] Brene Brown, *Atlas of the Heart: Mapping Meaningful connections and Language of Human Experiences* (New York: Random, 2021), 184.

[306] Brown, *Atlas of the Heart*, 185.

[307] LaRocca-Pitts M, *Love is all we need, Plain Views*, 3, no. 1 (November 2006), http://www.plainviews.org.

[308] Kirkwood, Pastoral *Care in the Hospital*, 114-117.

3.8.3 Theology of Acceptance

Jesus stated that he came for the needy and more so for those who were lost, helpless. This is shown in his testimony when he said in Matthew 9:13-13. He came to heal the sick and not the dead. This is an indication that he accepted all who came to him regardless of their infirmities.[309] The man of Gadara who was banished to the cemetery because of his hideous, uncontrollable manic behavior was healed by Jesus.[310]Again, although lepers were the untouchables of his day, Jesus not only cured them, but he also touched them, breaking the law and convention in doing so. By touching them, he reinforced the fact that he had accepted them as they were (Leviticus 13:14, Matthew 8:1-4). The chaplaincy ministry means moving out to accept the patients in their conditions, family, or staff whoever they are and whatever their ethnic background, religion. and state of their need.[311]

3.8.4 Theology of Renewal / Safe care

Jesus spent many hours of the early morning in prayer with God, renewing himself for the preaching, teaching, and healing ministry in Galilee (Mark 1:35-38). When in Jerusalem it was his habit to retire to the Mount of Olives each to pray (Luke 22:39). The chaplain needs to find ways to practice self-care which could be retreat, pray, silence, meditation, fast for the ministry and for himself. We cannot do it by our strength. It's God's work. Care of self, emotionally, physically, and spiritually, has long been an important aspect of spiritual caregiving for chaplains.

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[309] Kirkwood, *Pastoral Care in the Hospital,* 117-118.

[311] Kirkwood, *Pastoral Care in the hospital*, 119-133.

3.9 The Apostles and the Healing Ministry

Jesus expected his disciples, along with their teaching, to also heal. He sent them - the twelve disciples out to preach the kingdom of God and to heal the sick (Matthew 9:36, 14:14,15:32). Jesus told His disciples that what soever they do to the sick, they are doing it to Him (Luke 9:2, Matthew 25:36-40).

The Apostles were involved in the lives of the sick, vulnerable, and dejected in the order of their master the Great Physician (Acts 3:1-14). Peter, and John on their way to the temple healed a man at the Beautiful Gate. The man was lame from birth to show that this situation was not a small matter. It was not an acquired disorder. The man is congenitally lame from birth. A cure was unexpected, or impossible. He lacked hope for healing.[312] Peter and John used the same word "whole" to describe a disabled man's healing as Jesus did in John5:14. This tells us that healing was not just physical but involved all other facets that go along with it.

The lame man's healing brought him joy and to the crowd, it was something which they had never witnessed before (Acts 3:12). But the cessationist arrested Peter and John and commanded them to stop teaching in the name of Jesus (Acts4:1-20). They arrested them for teaching about Jesus' resurrection, but they were questioned about the healing. This is proof that they did not believe in miracles (Acts 4:5-7).

3.10 The Church and the Healing Ministry

The ministry of both Jesus and the apostles gives evidence that divine healing is integral to the proclamation of the gospel message. The church is mandated to go pray, heal, encourage, and show compassion for the sick. Although faith is important in the healing ministry, sometimes, God choose not to heal according to his sovereign purposes even when you exercised faith.[313]

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[312] Gaiser, *The International Bible Commentary*, 208.

[313] Grudem, *Systematic Theology*,1066-1067.

Jeus said Most assuredly, I say to you, he who believes in Me, the works that I do he will do also; and greater works than these he will do, because I go to My Father (John14:12-14 NKJV). **13** And whatever you ask in My name, that I will do, that the Father may be glorified in the Son. **14** If you ask anything in My name, I will do it.

James 5:14 (NKJV). Is anyone sick among you? let him call for the elders of the church; and let them pray over him, anointing him with oil in the name of the Lord:

James 5:15 (NKJV). And the prayer of faith shall save the sick, and the Lord shall raise him up; and if he has committed sins, they shall have forgiven him.

The hospital chaplain does what is also referred to as theological reflections**.** It is attempts to see God's presence in our experiences, to understand the difference His presence makes in our lives. It also helps in finding meaning in our experience.[314] It includes not only what is happening in the lives of the patient or relatives, but also causes the chaplain to do self-examination, a personal appraisal of his own theological involvement in the life of the patient he ministers to.[315] There are theological principles which need to be recalled by the chaplain. These are,

1.The principle of ministry. Pastoral care at the bedside must be done with Christian motive. The love for the patient and purity of heart should dominate a chaplain's thoughts. By this a chaplain faces reality with the patients. The chaplain is expected to instill hope in patients. Choosing the right words as he offers hope is vital and ethical so as not to exaggerate what need not to be exaggerated.

2. The principle of value. As Pastoral care givers, it is important to see each patient as one created in the image of God. When a person is sick or vulnerable, it does not mean he is stripped of his or her dignity. Manipulation of patients in their weakened

314 "A Framework for Theological Reflection," January,2021, https://www.mtso.edu.

315 Kirkwood, *Pastoral Care in the Hospital*, 2006, 243-244,257.

physical, mental, and emotional condition is anathema. Preserving the patient's dignity will keep the sustained even in pain.[316]

3.11 The Old Testament Concept of Suffering

First, God allows suffering to punish for sin (Deut. 30:19) and discipline His children toward godliness (Prov. 3:11, Job, Lam. 3, Jer. 8:18-21)

Second, suffering is allowed for the glory of God (Gen. 50:20). The example of Joseph in the book of Genesis gives us insight into how God used suffering and trials to foster His purpose by bring out the good in one's life.

Third, suffering is allowed to give evidence of our faith in God. The books of Job and Habakkuk show us that our response to suffering needs to be a righteous response in submission to the outworking of His plan and purpose in our life. One of the primary purposes of being shaken by suffering is to make our faith more unshakable. When one's faith is threatened and assessed and stretched to the breaking point, the result is greater capacity to endure.[317]

3.12 The New Testament Concept of Suffering

John 9:1-3 Here, we see an incident regarding a man who was born blind. The disciples saw the man and asked Jesus in verse two, "Rabbi, who sinned, this man or his parents, that he should be born blind? Suffering does not necessarily mean someone has sinned. Some suffering may be owing to specific sins in our lives and may not be. But the goal is the same in both: If there are specific sins in our lives, the goal of Christ-exalting

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316 Harvey Max Chochinov**,** "Preserving patients' dignity lends value to end of life," *Medical Ethics* (September 2017): 85-90.

317 John Timmerman, *A Suffering of Suffering: Our Family's Journey through Depression*, (Oregon: Multnomah, 2008), 161-162.

steadfastness includes recognizing and repenting of and moving out of those sins. If no sin, then the goal is still the same- magnify Christ through faith and repentance.

Romans 5:1-5. The believer can rejoice in suffering because suffering can produce something of value. It is beneficial. Suffering is not meaningless. Suffering makes us more resilient, better able to endure hardships. The aim of every trial in the Christian life is to make Jesus look great by our patience, our faith, our love for others in his goodness.[318]

3.12.1 Theological Concept on Suffering

Patients who have suffered from illnesses have this question to ask. "Why? Why me?" This question involves more than an explanation. Fundamentally it is a theological question. The question is not one that the patient alone faces. The pastoral care giver or the chaplain, also faces this question.[319] Neville states that when people ask Why, the safest and most trust-building response is to answer honestly, I don't know.[320] Never joke with the why questions or take light or simplify it to attempt shortcuts through it.[321] To some patients, God is testing their faith, it is a trial whose outcome will be for their ultimate. Viewing suffering as testing is seen in Paul's life. He pleaded with God to remove the thorn in his flesh, but God did not. This made Paul more God-dependent and tempered his ego.[322]The Bible says in Romans 5:3-5 (NKJV) that when tested, our suffering will produce the best character in us.[323] In Romans 8:28-39(NKJV), nothing can separate us from the love of God. Suffering comes along with grief, especially in the hospital. Patients, grief over their pain, the loss of their body organs through operations

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318 Timmerman, *A Season of Suffering*, 165-170.
319 Timmerman, *A Season of Suffering*, 168.
320 Kirkwood, *Pastoral Care in the hospital, 201.*
321 Kirkwood, *Pastoral Care in the hospital,* 97.
322 Kirkwood, *Pastoral Care in the hospital,* 208.
323 Henry, Commentary, 2204.

like amputation, total hysterectomy, stroke, or a modification of lifestyle due to an illness. This is because these losses make them not function the way they had originally been designed to.[324] The chaplain as the pastoral care giver journeys with them to find a new normal in which they can begin to function though with the loss. The chaplain is there to assist patients to validate their sufferings, to name the type of suffering, and to reauthor their story with a new meaning.[325]Meaning is the deep sense we make out of things, the way we understand the world, how we articulate the overarching purpose or goal of our lives, the significance we seek in living the core values by which we order our lives.[326] Meaning also include our theological dimensions, such as how we understand God's activity in the world, God's feelings about our troubles, and God's role in our suffering.

In accepting and sharing the pain of others, we incarnate our faith in the God who stands with us in their suffering, sharing their burden. Henri states that he who can articulate his own experience can offer himself to others as a source of clarification.[327] Campbell remarks that wounded healers heal because they, to some extent, have entered the depths of their own experience of loss and in those depths have found hope. [328]

3.12.2 What Does Suffering Do to Us?

Joseph Schumann, in a desiring God article gave three insightful things about suffering**.**

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[324] Stephen B. Roberts, *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplains' Handbook* (Woodstock, Vermont: Skylight Paths, 2011), 162-165.

[325]Brown, *Atlas of the Heart: Mapping Meaningful Connection and the language of Human experiences,* (New York: Random, 202), 88-90.

[326] Melissa M. Kelly*, Grief: Contemporary Theory and the Practice of Ministry* (Minneapolis: Fortress, 2010), 73-85.

[327] Henri Nouwen. *The Wounded Heale* (London: Longman and Todd, 1979), 40-41.

[328] Alastair A. Campbell, *Rediscovering Pastoral Care* (London: Darton, Longman and Todd, 1986), 42-43.

3.12.2.1 Suffering Equips us for Ministry.

Firsthand experience in suffering is essential in equipping us for ministry. Paul writes in 2 Corinthians 1:4 (NKJV), that God "comforts us in all our affliction, so that we may be able to comfort those who are in any affliction, with the comfoexperience sowe ourselves are comforted by God David Powlison states that: When you have passed through your own trials, and have found God to be true to what He says He is, you gain experience so that you can offer help to others.

I3.12.2.2 Suffering is a Battleground.

Wherever there is suffering, there is a battle- a battle for your soul. The book of Job shows us that there can be two ways to respond to suffering: one that curses God because of suffering and one that praises God in the midst of suffering (Job 2:9–10 NKJV).

3.13.2.3 Suffering Prepares Us for More Glory

Paul writes in 2 Corinthians 4:17–18, "This light momentary affliction is preparing for us an eternal weight of glory beyond all comparison, as we look not to the things that are seen but to the things that are unseen. For the things that are seen are transient, but the things that are unseen are eternal.[329]

3.14 Teams in the Bible

If the chaplain should perform his duties as demanded, he needs to collaborate with teams. Stan, Toler, defines a team as a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for

[329] Joseph Scheumann, "Five Truths About Christian Suffering, Arkansas," May 2014, https://www.desiringgod.org/.

which they hold themselves mutually accountable.[330] Just as important as it is for the chaplain to minister to patients in the hospital, it is also essential to be in the team that delivers quality care. Throughout scriptures, Biblical heroes did not work independently of others. In fact, the Bible does not emphasize solo ministry. Its pages are filled with stories of great collaborations: Moses and Aaron, Caleb and Joshua, Esther and Mordecai, Ezra and Nehemiah, Peter and John, Paul and Timothy, Barnabas, and Mark. Jesus made teamwork a priority in his ministry (Exodus 4:10-17, Numbers13:17-18, Esther1, John3;1-11, Acts16:16-34).

3.14.1 Teamwork in the Old Testament

In Exodus17:12-13 And Aaron and Hur supported Moses' hands, and this brought them victory. As a team, we can accomplish far more than we can alone.

Moses was an incredible leader, but he needed a team, and God gave him Joshua, Aaron, Hur, and Caleb to share the load of leadership. Through his father-in-law, he became aware of his personal weaknesses, and learned to divide his leadership responsibilities into manageable portions that were delegated to a team of gifted servants.

Ecclesiastes 4:9-12 speaks of the value of teamwork: "Two are better than one, because they have a good return for their labor: If either of them falls, one can help the other up. But pity anyone who falls and has no one to help them up.

Teamwork was shown in rebuilding the Wall of Jerusalem in Nehemiah 4:1-14. When the Israelites were rebuilding the wall in Jerusalem, the work got tough, and they got discouraged. So, Nehemiah reorganized the work, he divided the people into teams. Half would stand guard with their spears and swords and protect everyone, while the other half would be at work. Then they exchanged or swapped their positions. He posted

[330]Stan Toler, *Leader-Coach: Developing Effective Ministry Teams* (Kansas: Beacon Hill, 2013), 14-15.

everyone by groups and families, so they could encourage and support each other. The shift continued until work was accomplished. The task became a collective effort where everyone became involved in a common goal. Nehemiah relied on teams to restore the walls of Jerusalem.[331]

Proverbs 27:17 states, as iron sharpens iron, so one man sharpens another.

3.15 Teams in the New Testament

In **Mark 6:7,** it states that, And He called the twelve to Himself, and began to send them out two by two, and gave them power over unclean spirits. This shows that Jesus did not expect them to minister alone but in team.

In the book 1and2 Corinthians, the apostle Paul acknowledged that his ministry accomplishments were achieved with the help of many other people. Their love, encouragement, prayers, and financial support were indispensable to his success as recorded in 2 Corinthians 1:11, 1 Corinthians 16:17 18, Romans 16:1– 6, and Philippians 2:17–30.[332]

In **1Corinthians12: 20-25**, the bible indicates that the eyes can never say that they do not require the hands to perform their duties. All body parts are indispensable. Despite how weak some body parts may seem; they all have a specific duty to perform.

3.16 Conclusion

In chapter three, Biblical and theological concept of healing were examined from the OT to the NT. The different types of illnesses were also listed which were mental, spiritual, and physical. These illnesses brought untold suffering to patients. Visitation to a hospital patient's bedside appeals to the chaplain as a fruitful and rewarding Christian

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[331] Lencioni, *The Five Dysfunctions of a Team*, 174.

[332] Toler, Leader-*Coach,* 9-10.

service. A sincere desire to support and comfort an ill patient, bringing hope and encouragement stirs up the faith of the patient. The chaplain's healing ministry is ground in Scriptures which states that God comforts us in every trouble so that we may also be able to comfort (Love, care) those who are in trouble or distress, with the comfort with which we have received from God. For a chaplain to effectively minister to the sick, he needs a team which is the health care team with which they will collaborate so that holistic care can be achieved.

CHAPTER 4

RESEARCH METHODS AND PROCEDURES

4.1 Introduction

The purpose of this chapter was to examine, through the lived experiences of the chaplains the perception of the role of the hospital chaplain in the MDT in the Cameroon Baptist Convention. The methodology and procedures used in drawing information from the twenty-five chaplains of the CBC respondents, and analysis of data were employed. The research methods employed were phenomenology and triangulation methods.

In this process, the following procedures and processes of investigations were undertaken. They included the qualitative interview method, the instruments used, the reliability and validity, interview analysis procedure, sampling, interview analysis procedure.

4.2 Research Methods

4.2.2 Phenomenological Method

A phenomenological method was used to investigate the lived experiences of chaplains.[333] It also investigated the common phenomenon of chaplains which showed how they were underused, misunderstood, perceived. Phenomenology is the strategy of

[333] John W. Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (Los Angeles, CA: Sage, 2009),12-14.

inquiry in which participants identify the essence of human experiences, lifeworld, and social action**.**[334].[335]The data was collected was developed into themes that reflected the experiences of the participants in the MDT.

4.2.2 Triangulation Method

This method makes use of multiple sources of data, to confirm emerging findings, and to extract the required information as well as critically analyzing findings. Triangulation mainly helps in validating the results of a study. Triangulation helps to confirm research findings, decreases deficiencies from one source, and provide more insights.[338]

4.3 Qualitative Interview

The qualitative interview format of data collection was employed, and it was the basic method of inquiry and, sourcing of data collection in qualitative studies.[336] Interview is a process in which a researcher and participant engage in a conversation focused on questions related to a research study.[337] The data collected was through interviews was a preferred method.[338] Semi-structured, and open-ended interview format were used.[339] Online interviews were employed via the use of (Phone calls, WhatsApp video, zoom, emails). Hard copies were sent to participants who could not be reached via email.

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[334] Merriam Sharan and Elizabeth Tisdel, *Qualitative Research: A Guide to Design and Implementation* (Wiley Brand: Jossey-Bass, 2015), 26-30.

[335] Joseph A. Maxwell, *Qualitative Research Design: An Interactive Approach* (George Mason University, 2012), 214-215.

[336] Irving Seidman, *Interviewing as Qualitative Research: A Guide for researchers in Education and the Social Sciences* (New York: Columbia University Press 2014), 8-9.

[337] Sharan and Tisdel, *Qualitative Research,* 108.

[338] Juliet Corbin, *Basics of Qualitative research: Technics and Procedures for Developing grounded Theory* (Los Angeles, CA*:* Sage, 1996), 37-38.

[339] Sharan and Tisdel. *Qualitative Research,* 110.

Using probing, questions were asked for more clarification or details[340] At the end of the interview, a thank you statement was given.[341]

4.3.1 Instruments

The researcher was the primary instrument for data collection and data analysis.[342]The chaplains of the CBC were chosen as my participants. The researcher was a chaplain in this organization before.

4.3.2 Setting

The Participant were chaplains that were currently working on MDTs in hospitals within the CBC in the Northwest, Southwest, Littoral and Centre Regions of Cameroon.

4.3.3 Sample Size

The participants were chaplains who were working with the Cameroon Baptist Convention Health services, a degree in theology, and had undergone a basic CPE unit1 training. The number of participants for the phenomenological research was twenty-five. The twenty-five chaplains were from the seven hospitals of the CBC.

4.3.4 Ethical Issues

Ethical considerations are issues that need to be addressed throughout the process of the research design. The participants interviewed were kept anonymous so that their identity could be known. [343] Again, Pseudonyms kept all the initials of the participants neutral.

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[340] Sharan and Tisdell. *Qualitative Research*, 123.
[341] Sharan and Tisdell. *Qualitative Research,* 244.
[342] Sharan and Tisdell. *Qualitative Research*,16.
[343] Corbin, *Basics of Qualitative Research,* 80.

Consent and confidentiality were explained to the chaplains during the interviews. Sharan, says that the protection of participants from harm, the right to privacy, the notion of informed consent, all need to be considered ahead of time.[344]

4.3.5 The Interview Analysis

Data analysis was conducted on the participant's responses to the research question, interviews, and observations. The research questions helped in investigating the lived experiences and perceptions of the chaplains in the MDT. Questionnaires were served to chaplains who could not be reached by phone, what apps or direct call. The researcher made use of probes in which she asked individuals to explain. Probes are also questions or comments that follow up on something already asked. Reflective and descriptive field notes were also taken and completed as an observational protocol. With regards to memo writing, information which was of primary importance was recorded. At the end of the interview, a thank you statement was given.[345]

Qualitative data analysis seeks to identify themes, categories, patterns, or answers to research questions. Several categories were generated and trimmed down to core concepts that gave meaning to the research. Words and phrases that were dominant were grouped which then were catalogued into themes.[346] The thematic analysis facilitated the production of data from interviews.[347] These themes were captured through interviews, as it was relevant to the research topic.

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[344] Sharan and Tisdell, *Qualitative Research* 261.

[345] Creswell, *Research Design,244.*

[346] Corbin, *Basics of qualitative research*, 298-299.

[347] Sharan and Tisdell, *Qualitative Research,* 178.

4.3.6 Data interpretation

Interpretation involves making sense of the data, and the lessons learned. In qualitative data interpretation, researchers seek new knowledge and insight into phenomena. Data interpretation refers to the collection of data from one or more sources, analyzing and reviewing it using appropriate methods for the purposes of drawing meaningful conclusions.

4.3.7 Reliability and Validity

The validity of this research was established using the qualitative method employed stated above. [348] Emails, what app and zoom were used for the interviews. Questionnaires were sent to those who could not be reached on the phone. Another way I ensured credibility and validity was through member checks. The researcher solicited feedback on preliminary or emerging findings from some of the participants.

4.4 Conclusion

In this chapter, the purpose of the study was introduced and the rationale for the phenomenological study stated. The methodology for the selection of participants was described which was the qualitative one. It made use of the phenomenological and triangulation method methods. The methodology for the selection of participants was described. A description was provided of the instrumentation to be used for data gathering and its sufficiency to answer the research questions. Details explaining procedures for recruitment participation, and data collection were explored followed by the plan for data analysis. Ethical considerations were taken care of to ensure confidentiality. I worked on credibility by checking the accuracy of the data collected. Qualitative interview helped the researcher gain information that was helpful in

[348] Creswell, *Qualitative Research Design*, 126-127.

developing themes or operational definitions that guided the researcher in analysis and integration of findings in a comprehensive manner.

CHAPTER 5

RESEARCH FINDINGS AND DATA COLLECTION

5.1 Introduction

This chapter presents the data obtained from the twenty-five chaplains interviewed from five major hospitals and their sub health centers of the Cameroon Baptist Convention. The phenomenological method was used to collect the data. My rationale for using this method was to thoroughly investigate the phenomenon so that rich data could be obtained about the lived experiences of the chaplains on the perception of the role of the hospital chaplains in the MDT in the Cameroon Baptist Convention. Interviews were conducted, and questionnaires were also administered to those participants whom the researcher could not reach out to due to poor net network in some areas of the study location. Semi-structured interviews questions were asked which gave the flexibility for adding probing, prompts, and follow-up questions. A consent form was read to the chaplains which reassured them of the confidentiality that was involved in the data collection.

The data that was obtained included the following, age range, composition of MDT, the perception level, valued level, their role (compassion, empathy, care), qualification, recognition level, holistic care, referrals, gender, and educational awareness.

5.2 Study Location

The Study area is located within Cameroon Baptist Convention which is spread across the ten regions of Cameroon. The hospitals are the Mbingo Baptist hospital, Nkwen Baptist hospital, Baptist Hospital Mutentengene, Mboppi Baptist hospital Douala, Etoug- Egbe Baptist Hospital, Ekoudom Baptist hospital, Bonaberi Baptist Hospital, Voudou Baptist health Centre, and Ndu Baptist health center. The CBC has its headquarters in the Northwest Region, precisely Bamenda. Cameroon Baptist Convention Health Services is situated on Latitude 5°57'46.9836 N and 10°9`32.8356``E and 1282.285 m above sea level.

5.3 Materials

- Laptop Intel core17
- Handset, mark, and type
- Zoom
- WhatsApp
- Direct phone calls

5.4 Method of Data Collection.

For this qualitative study, a variety of methods were used to conduct the interview, which guided and shaped how the introduction, interview questions, probes, conclusion, and debriefing were done. The semi-structured protocol with a list of questions specific to the research topic was administered. This method uncovered and obtained detailed information. The participants were fully briefed on the format, purpose, and what the research was aimed at achieving. The open-ended questionnaires were sent out to the participants whom the researcher could not reach to them on phone or

WhatsApp. The participants provided in-depth answers to the questions that were asked, and then extrapolated large amounts of data which help me in my analysis.

Online interviews using Phone calls, WhatsApp video and zoom were equally used. This was typically verbal interviews with a video component that were more like face-to-face interviews. In addition, voice-to-voice real-time interviews over the telephone by making direct calls to some of the interviewed participants were employed.

The researcher drew together some information which formed themes that were running through the narratives of the lived experiences of the participants.

5.5 Data Presentation

Table 5.1 shows data obtained from the twenty-five chaplains of the different hospitals of Cameroon Baptist Convention who were interviewed.

TABLE 1. DEMOGRAPHICS OF THOSE INTERVIEWED

S. NO.	Pseudo-nyms Initials	Age Range	Gender	Referrals	Perceived Level	Qualification	Recogn-ition Level	Valued Level	MDT	Factors MDT	Holistic Care	Qualities of Chaplain
1	BC	31-40	Male	low	Poor	Theology/ CPE	Yes	No	N, Dr, Ch, Sc, Pharmacist.	Communication, Teamwork	Body, soul mind	Love, care. compassion
2	MA	41-50	Female	Timid	Poor	Theology/ CPE	Yes	No	Nurse, Dr, Ch, Sc	Communication Commitment	Spiritual Physical emotional	Empathy, Compassion, Listen
3	DK	51-60	Female	Average	Poor	Theology/ CPE	Yes	No	Dr, N, Sc, Pharmacist	Trust, teamwork Communication	Physical, spiritual, mental	Compassion Care, Empathy
4	HLN	41-50	Female	Low	Poor	Theology/ CPE	Yes	No	Pharmacist, Dr, Sc, Ch	Trust, togethernes s	Emotion, physical, spiritual	Empathy, Care
5	LWK	31-40	Female	Low	V poor	Theology/ CPE	No	No	Dr, Ch, Sc, Physiotherapist	Communication, together Respect Shared goals:	Take care of wholeness	Confidential Compassion, care
6	BS	41-	Femal	Low	Averag	Theology	Som	Yes	N, Sc,	Trust,	Spiritual,	Compass

S. NO.	Pseudo-nyms Initials	Age Range	Gender	Referrals	Perceived Level	Qualification	Recogn-ition Level	Valued Level	MDT	Factors MDT	Holistic Care	Qualities of Chaplain
		50	e		e		etimes		Pharmacist, Ch	communication Clear goals	physical emotional	ion, Empathy, Care
8	JE	31-40	Male	Low	sometimes	Theology/ CPE	Sometimes	Yes	Dr, N, Ch, Sc, Nutritionist, Pharmacist	Boundaries, respect, Communication	Physical, spiritual, mental	Empathy, Care, Presence
9	GF	21-30	Female	Good	Poor	Theology/ CPE	Average	No	Sc, Ch, N, Pharmacist	Solid relationships Communication	Physical, spiritual, mental	Compassion, Care Empathy, Listen
10	CD	31-40	Female	Sometimes	Poor	Theology/ CPE	No	No	Dr, Ch, N, Pharmacist Physiotherapist	Communication, trust, Value others	Physical, spiritual, mental	Love, Empathy Care, compassion
11	DB	51-60	Male	Below Standard	Poor	Theology/ CPE	No	May be	Dr, Ch, Sc, Pharmacist, N	Purpose, Communication Respect, teamwork	Spiritual, physical emotional	Presence, care, compassion Empathy
12	WR	41-40	Female	low	Poor	Theology/ CPE	Average	No	N, Sc, Ch, Pharmacist, Mental Nurse	Trust, teamwork communication	Spiritual, physical emotional	Care, Compassion,
13	NE	31-40	Female	low	Good	Theology/ CPE	Yes	Yes	Nutritionist, N, Ch, Dr, Pharmacist	Communication Discipline:	Spiritual, physical emotional	Empathy, Love, compassion, Care
14	NM	41-50	Male	Low	Poor	Theology/ CPE	No	No	Pharmacist, N, Ch, Sc, Dr, Physiotherapist	Respect, clear goals, Good relationship	Physical, spiritual, mental	Compassion, Care Empathy,
15	FB	21-30	Female	Low	Poor	Theology/ CPE	Yes	No	Dr, N, Ch, Sc	Communication, respect	Spiritual, physical emotional	Compassion, Empathy
16	FF	41-40	Female	Low	Poor	Theology/ CPE	Yes	No	Dr, N, Ch, Pharmacist,	Togetherness Communication, Discipline:	Physical, spiritual, mental	Care, Compassion, Love
17	JJ	41-50	Female	Average	Poor	Theology/ CPE	Yes	No	Ch, Dr, N, Sc,	Communication, value, trust,	Spiritual, physical emotional	Empathy, Compassion Care
18	AG	51-60	Female	Average	Poor	Theology/ CPE	yes	No	Dr, N, Sc, Pharmacist, Ch	Teamwork,	Physical, spiritual, mental	Care, Love, Empathy,
19	AJ	31-40	Male	Low	Poor	Theology/ CPE	Yes	No	N, Dr, Sc, Ch, Pharmac	Communication, trust	Physical, spiritual, mental	Empathy, Care compass

S. NO.	Pseudo-nyms Initials	Age Range	Gender	Referrals	Perceived Level	Qualification	Recogn-ition Level	Valued Level	MDT	Factors MDT	Holistic Care	Qualities of Chaplain
									ist			ion
21	BR	31-50	Female	Low	Poor	Theology/ CPE	Yes	No	Pharmacist, Dr, N, Ch, Pha	Respect, Discipline:	Physical, spiritual, mental	Care, Love, Compassion, Empathy
22	GT	50-60	Male	Average	Poor	Theology/ CPE	Yes	No	Pharmacist, N, Dr, Ch,	Communication, Trust	Physical, spiritual, mental	Empathy, Love, Care
23	IJ	31-40	Female	Average	Poor	Theology/ CPE	Yes	No	Dr, Ch, Pharmacist, Nutritionist, N	Communication,	Physical, spiritual, mental	Compassion, Empathy, Care
24	DE	41-50	Female	Low	Poor	Theology/ CPE	Yes	No	Dr, N, Ch, Pharmacist,	Teamwork	Physical, spiritual, mental	Care, Empathy, Compassion
25	CD	41-50	Male	Low	Poor	Theology/ CPE	Yes	No	Dr, Ch, N, Pharmacist Nutritionist	Discipline, Shared goals:	Spiritual, physical	Compassion, Empathy, Care.

Results, discussion, and analysis of this demographic information are done in chapter Six.

5.7 Conclusion

In summary, the research questions were used to investigate the lived experiences about their perception in the MDT in the CBC. Through these research questions, rich data describing the lived experiences of the chaplains was obtained. The nature of the questions comprised of open-ended questions, semi structured, flexible, and exploratory in nature. Interviews allowed participants to describe their lived experiences, personal feelings, and opinions. Questionnaires were served to gather information from the chaplains who could not be reached by phone. The results were put in a table format to facilitate data analysis and discussion.

CHAPTER 6

DISCUSSION AND ANALYSIS OF FINDINGS

6.1 Introduction

The purpose of this phenomenological study was to explore, review and examine, through the lived experiences of chaplains of the CBC about the perception of their role in the MDT. In this chapter, the results obtained from the interviews and questionnaires that were conducted with the twenty-five chaplains from seven major hospitals of the Cameroon Baptist Convention were analyzed and discussed.

The phenomenological method was used and the rationale for using this method was to thoroughly investigate the phenomenon so that rich data of lived experiences of the chaplains on the MDT. Another rationale was to get meaning from their experiences.

A review of the literature showed that much of the available research on chaplains in healthcare has been directed at services that chaplains provide, how they provide them, their role, and, leaving a gap in the literature regarding how they were perceived on the MDT. Identification of factors that influenced these experiences were essential to the development of programs or review of policies, which could assist chaplains in rendering compassionate services thus achieving holistic care.

Key findings from the study revealed several prominent themes, which were helpful in gaining a better understanding of the perception of the role of the hospital chaplain in the MDT in the CBC.

The demographic information, which was collected included age range, the perception of the role of the chaplains, how chaplains were valued, referral notes to the chaplaincy, barriers in communication, awareness, and character traits (care, compassion, empathy). The results of the interview were discussed and analyzed below.

The findings were discussed as follows. The responses of chaplain on the interview question were compared with the secondary sources in the literature review thus forming key themes. The themes that emerged were the primary sources which provided credible evidence for my research topic.

A review of the literature had shown that most of the research on hospital chaplains had focused on the role of the chaplain, and little has been done on the perception of their role thus creating a gap in the literature regarding how they are underused.

6.2 Results and Discussion

6.2.1 Sample Size

The findings of this research confirm the contexts in which chaplains worked. As observed from Table 6.1 below, twenty-five chaplains were interviewed from seven different hospitals of the CBC. Majority of the participants in the interview were females. When the question was asked why females were dominating, some chaplains reported that most male chaplains would rather prefer taking up church ministries due to the poor perception. Two chaplains commented that the female chaplains accept hospital ministries because the church does not accept females as pastors and so they were left with hospital ministry. This explains why they had more female respondents than male. Four chaplains said it did not matter whether some were male or females, but their calling, qualification and competence made them professional chaplains who could offer

spiritual care. With the theological and CPE education that the chaplain has acquired, he is competent and is able to integrate spiritual perspectives into his pastoral care in the hospital.[349]

The age range gave an understanding that chaplains who were employed were those who were mature and had direction as to their calling. Two chaplains commented that no patient will trust a chaplain that is immature in their reasoning. The pseudonym was an initial concealed identity of the chaplains who participated in the interviews. This gave the participants a sense of control and anonymity, making them feel more comfortable sharing sensitive information and participating more freely.

6.3 Themes that Emerged from the Interviews and Questionnaire.

From Table 6.1 and Figure 6.1, the following themes were generated in accordance with the significance to which the participants attributed them. How chaplains were perceived in the MDT, communication breakdown, Character traits (empathy, compassion, care), the way chaplains were regarded and valued, creating awareness through education, holistic care, and composition of the MDT.

6.3.1 The Perception of the Role of the Chaplain.

Table 6.1 and Figure 6.1 show the results obtained for the perception of the role of a chaplain. These were the assigned units in which the chaplains were regarded as being present to focus on spiritual needs of the patients, the families, caregivers, and the staff so that they could find meaning and purpose in life. 8/25 reported that they knew what to do in any given interventions. 5/25 reported that sometimes the work is overwhelming which made them confused but now without a clue. 2/25 chaplains said

[349] Roberts, *Professional spiritual, and Pastoral care*, 40-45.

the basics duties were known to them. This was because intervention of various kinds kept challenging. Some said they had an idea of what to do at a given time. From the above responses, it was gathered that the chaplains were knowledgeable about their role.

Chaplains are pastoral practitioners who seek to build a relationship of trust through compassionate presence and thereby offer help and support to a diversity of people.[350] Gillian White has commented that hospitals values chaplains, but they do not understand their role, and how to integrate them within the context of the hospital. Health care chaplains are regarded as an asset but without a proper understanding of their role in MDT they cannot be made useful. To some chaplains, they felt underuse, and this was largely because of the way the MDT perceived them and thus their role. Some said a chaplain needs to take proactive steps to make their role known and enter the wards for pastoral care rather than waiting for patients to be sent to them from the MDT. Gillian, White, who is clinical dietetics says that chaplaincy services is under the threat of marginalization.[351] Koenig comments that chaplains are trained to deal with patients from many different religious backgrounds and those with no religious backgrounds. Taking care of patients' spiritual needs is the chaplain's primary responsibility, regardless of the MDT's perceptions.[352] The chaplains are trained and prepared to address the spiritual and emotional needs that patients experience when they are sick and in the hospital.[353] For that reason, they should be fully utilized for most spiritual issues patients are screened for. Some MDT members have always felt that they can do the work of the chaplains

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[350] George Handzo, and Harold Koenig, *Spiritual Care, Whose Job is it Anywhere? Sothern medical Journal* 9, no.12 (December,2004):1240- 1243. DOI: 10.1097/01.SMJ.0000146490. 49723.AE

[351] Gillian White, *Talking about Spirituality in Health Care Practice: A Resource for the Multi-Professional Health Care Team* (London: Jessica Kingsley, 2006), 50-51.

[352] James Ashbrook, *The Impact of the Hospital Situation on Our understanding of God and Man* (Council for Clinical training Inc, 2011), 1-15.

[353] Belgum, *Religion and Medicine*, 91-110.

which is improper.[354] Puchalski reiterates that chaplains are trained to provide in-depth spiritual counseling, and typically possess extensive training in pastoral care.[355]

6.3.2 Referrals to the Chaplaincy Department

From Table 6.1 and Figure 6.1, 17/25 chaplains reported that referrals were less from the MDT, about 5/25 rated that referrals were average. A chaplain reported that referrals were timid, which disturbing because MDT could refer patients to other department but when it comes to the turn of the chaplains, they do not want it. Another chaplain commented that he was satisfied with referrals from his unit. Most of the chaplain noted and commented that the low referrals from the different units could be attributed to ignorance. A chaplain said even when there is a case before the MDT that needed spiritual interventions, still, they ignored and neglected it. When the researcher asked about contributing factors to low referrals, as seen from

6.3.3 Barriers in Communication

Figure 6.1, 17/25 of the chaplains responded that there was a breakdown in communication which affected them in the way they conducted work assignments. Some chaplains said the MDT needed to work on interpersonal skills which upheld respect, acceptance, team dynamics, and collaboration. Another respondent reported that MDT was a place where communication should have flown most to enable them to do comprehensive care to the patients. Some chaplains noted the importance of building relationships within the team to develop a strong support network. A chaplain reported that the team that wins is that which value relationships and treats every member of the team with respect and dignity. The researcher noticed most of the responses coming from

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354 Koenig, *Medicine, Religion, and Health, 61*-65.

355 Puchalski, *The role of spirituality*, 16-25.

the participants centered around the problems of communication, education Even though MDT strives towards the common goal of providing quality care to patients, there are some challenges to the delivery of care, which is conflict, role boundary, lack of respect.[356] As an MDT, they should note that effective communication is key to thinking collectively and finding synergy in team solutions. Rod Lorne Iwanow confirms that a breakdown in communication is a catalyst for conflict because team members are unwilling to listen in an authentic way to other opinions and instead promote entrenched views of their own.[357] As a result, an MDT must approach communication with a determined intentionality and allowing each member to express themselves.[358] Netto agrees by stating that if communication is made effective within the team, it eliminates confusion and fosters a healthy and happy workplace. This entails team members choosing their words carefully. Effective communication within the team will allow the work to get done more quickly and efficiently.[359] Clinebell has suggested some essentials for physician-chaplain relationships which are, mutual understanding and appreciation of each other's unique competencies, views, insights, and contributions, willingness to communicate, and be open to learn from each other because nobody is above learning.[360] In the health care system, you can never claim the "Know All Attitude,"[361]

A chaplain mentioned that if the MDT could have seminars on what MDT is all about, team dynamics, it could help harness how they could relate to each team member. Some chaplains responded that in a hospital, the goal is patient care. Patients suffer when there is a breakdown in communication. Koenig remarks that some MDT members argue that consent be obtained from the patient on whether they want to see a chaplain before

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356 Lencioni, *The Five Dysfunctions of a Team,* 188-191.
357 Iwanow, *Exploring Conflict within Multidisciplinary Teams*, 47-48.
358 Iwanow, *Exploring Conflict within Multidisciplinary Teams*, 38-39.
359 Netto, *Building High Performance Teams and its Sustenance*, 6-7.
360 Kuebler, Davis, and Moore, *Palliative Practices*, 60-65.
361 Clinebell, *Healing and Wholeness*, 1971,11-18.

referrals are done. Some patients do feel reluctant to see a chaplain. This reluctance usually comes from lack of knowledge about who a chaplain is and does.[362] Most patients and even some MDT members think that a chaplain is simply there to pray with patients, talk about religion, perform religious rituals, and conduct chapel services.[363] While the chaplain may do all of these, there is a lot more as well. They are trained to walk alongside patients, wherever those patients are in their spiritual journey, visiting and talking with them about issues that are important to them and to help them find meaning and purpose in life. If this journey brings them to an encounter with Jesus Christ, we celebrate God for that. Even if it does not, the seed has been planted. The God that brings people to himself will do a quick work in their lives through the ministry of the chaplain. So, referrals of patients to the chaplaincy department were important. Therefore, the clinician may need to explain to the patient what a chaplain does.

6.3.4 How chaplains are valued in the MDT.

From Table 6.1 and Figure 6.1, Out of the number of chaplains interviewed. 19/25 chaplains felt that they were not valued.3/25 said they were valued, 1/25 said maybe. The chaplains acknowledged that they were recognized but not respected and not well treated, which affected their presence on the team. A chaplain reported that he felt disrespected, relegated to the background when he was sidelined from ward conferences. Some chaplains said when MDT does not value their services, the tendency is that the chaplains will be underused. One participant discussed how the chaplain is an irreplaceable component of the team but underutilized. The majority of the participants indicated the chaplain is considered a voice for the patient in matters of ethical considerations and

[362] Koenig, Handbook *of region and Health*, 298-300.

[363] Paul E. Johnson, "*Mental Hygiene*," *Religious Psychology and Health* 32, no.1 (October, 2005): 556-560.

spiritual issues. One participant commented on the value of spiritual care being crucial for the vulnerable populations dealing with advanced illnesses.

Interestingly a chaplain remarked that some chaplains are not used and valued because they are never available in their wards when the MDT needs them. He further commented that the lack of chaplains in the team meeting, ward conferences, ward reports have further deepened the way they were regarded and valued especially when the MDT wanted to get information and feedback from chaplain, and they were not available on the MDT. This chaplain continued that when the chaplain was absent from the MDT for a while, the team took alternatives to either do the chaplain's work, which subsequently rendered the chaplain valueless or relegated. Some chaplain said low salaries for chaplains were indicators that their services were not needed.

Vandecreek noted that the difficulties chaplains encounter in the MDT is stemming from the fact that the team is unable to translate what chaplains do.[364] The communicative process of rendering concepts associated with the chaplains' profession into terms that can be understood and utilized in the healthcare setting is sometimes lacking. [365] Emily M. Cramer, associate professor of health and strategic communication at Howard University comments that chaplains may struggle to negotiate their role among members of the healthcare team, which is difficult at times. Williams, Mari, Lloyd a co-editor in a journal sates that chaplains continue to strive for legitimacy and recognition in healthcare institutions, despite extensive training and the proven benefits of spiritual care to patients. Williams comments that a chaplain's role on the team may vary and lack clarity, which increases levels of perceived stress thus making

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364 VandeCreek, *Spiritual Needs and Pastoral Services, 45-50*.

365 Emily M, Crame Kelly, and Mike Allen, "Translating Spiritual Care in the Chaplain Profession," *Journal of Pastoral Care & Counseling Advancing theory and professional practice through scholarly and reflective publications* 67, no. 6 (March 2013): 3-5. DOI: 10.1177/154230501306700106.

them to be unimportant.[366] Chaplains in the CBC have continued to provide a much-needed service to patients and families, despite these difficulties that have plagued them.

With regards to Marginalization, most of the chaplains commented that their role was not regarded because they were marginalized, minimized, and relegated to the background. Some chaplains made statements that everybody feels that they can do the work of a chaplain. One of the participants said MDT behaves sometimes as if everybody knows their role except the chaplain. This was proven by the fact that some MDT members do not respect boundaries of professionalism and so they step in to do the work of the chaplain. Yih states that chaplains live in constant tension between adapting to their marginalizing conditions and striving to retain the essential values of their role. But in this tension, some aspects of those essential values are also lost.[367]

6.3.5 Awareness

Nearly all chaplains interviewed reported that creating awareness through education, sensitization and seminars could give the MDT a healthy environment to work in. A chaplain remarked that the administration could add their voice to the voices of chaplains as authority figures so that stigma could be taken care of. Some chaplains reported that fresh staff who were recruited into the CBC health services could be given proper orientation on the chaplains' role, and what the MDT is all about. 3/25 chaplains also observed that the confusion about their role and poor perception also stem from the fact that some chaplains lacked professionalism in the MDT thus creating a poor image about chaplains. He commented that chaplain's identity and their professional ethics guidelines needed to be revisited by some chaplains. A chaplain commented that creating awareness needed to be a two-way issue. The chaplains had a part to play in the MDT

[366] Mari et al., *A Prospective Study of the Roles, Responsibilities*.
[367] Yih, *The Chaplain Grieves in Silence, 5*.

also. Emily confirmed that chaplains facilitated the process of translation by asserting themselves in interactions with medical staff.[368]

6.3.6 Qualities and Traits of Chaplains.

From table6.1, Of the twenty-five chaplains interviewed, the majority came out with these three qualities that stood outstanding in their comments. Compassion, Empathy and care.

6.3.6.1 Compassion.

A chaplain said that compassion moves them to mourn with those who are mourning and to rejoice with those who are rejoicing. A chaplain reported that compassion is a quality that is important for it goes with listening. Other chaplains said that a compassionate attitude was a virtue to always cultivate. Some chaplains said through compassion, they provide emotional support to patients and their families. Henri says that compassion requires the chaplain to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless.[369] Compassion means full immersion in the condition of being human.[370] It is the daily practice of recognition and accepting our shared humanity so that we treat ourselves and others with love and kindness, and to act in the face of sickness. Some chaplains commented that their goal was to treat patients with respect regardless of who they are or what their background was. Compassion is fueled by understanding that we are all made up of strength and struggles.[371] No one is immune to pain or suffering. In cultivating compassion, we draw from the wholeness of our experience and our sufferings. Compassion challenges us to cry out with those in

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[369] Nouwen, *Creative Ministry*, 60.
[370] Nouwen, *Creative Ministry,* 65.
[371] Kirkwood, *Pastoral Care in the Hospital,* 122.

misery, to mourn with those who are lonely, to weep with those in tears. Compassion requires the chaplain to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless all the time[372]

6.3.6.2 Empathy

18/25 participants commented that if they were not empathic, through listening, feeling the for the patients, their care could be superficial. Most of the chaplains reported that empathy was their number quality. A chaplain said empathy to him was a lifestyle as he worked with patients. 5/25 chaplains reported that empathy and compassion were all good qualities of equal values to a chaplain. Empathy is an emotional skill that allows us to understand what someone is experiencing and to reflect that understanding.[373] Another chaplain commented that empathy made him to always lay down his life for the patients he ministered to.

Kirkwood states that empathy is the ability to enter and share the feelings of another person whether they are positive or negative reactions to life's situations.[374]We can respond empathically if we are willing to be present to someone's pain. If we are not willing to do that, it is not empathy. There are two sides to empathy, cognitive empathy which is the ability to recognize and understand another person's emotions while affective empathy is when you are in tune or aware of another person's emotions.[375] Brene Brown states that rather than say empathy is walking in some's shoes, we need to learn to listen to the stories patients tell about what it is like to be in that sickness or pain and believe them even when it does not match the chaplains' experiences.[376]

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[372] Nouwen, *Creative Ministry*, 60-62.
[373] Brown, *The Atlas of the Heart,* 121.
[374] Kirkwood, *Pastoral Care*, 115-117.
[375] Brown, *The Atlas of the Heart*, 121-122.
[376] Brown, *The Atlas of the Heart*, 123.

6.3.6.3 Care

21/25 chaplains responded that care is another quality that defines their profession. Some chaplains concorded that the term care is always used to describe the work and value of the chaplain. Another respondent said that chaplains were called pastoral caregivers, and such a term could not be ascribed to a chaplain who could not give out care. A chaplain noted that nobody cares how much you know unit they know how much you care. Taku noted in his write up that the chaplain should be an embodiment of care which includes attentive listening, comforting, touch, honesty, providing clear information so that patients are fully informed on spiritual issues, and find meaning and purpose in their lives.[377] Caring can contribute positively to the satisfaction and the wellbeing of patients by decreasing anxiety and alleviating pain. Therefore, empathy is understanding what someone feels and not feeling for them.

TABLE 2. DEMOGRAPHICS OF THOSE INTERVIEWED

S.NO.	Pseudonyms Initials	Age Range	Gender	Referrals	Perceived Level	Qualification	Recognition Level	Valued Level	MDT	Factors MDT	Holistic Care	Qualities of Chaplain
1	BC	31-40	Male	low	Poor	Theology/CPE	Yes	No	N, Dr, Ch, Sc, Pharmacist.	Communication, Teamwork	Body, soul mind	Love, care. compassion
2	MA	41-50	Female	Timid	Poor	Theology/CPE	Yes	No	Nurse, Dr, Ch, Sc	Communication Commitment	Spiritual Physical emotional	Empathy, Compassion, Listen
3	DK	51-60	Female	Average	Poor	Theology/CPE	Yes	No	Dr, N, Sc, Pharmacist	Trust, teamwork Communication	Physical, spiritual, mental	Compassion Care, Empathy
4	HLN	41-50	Female	Low	Poor	Theology/CPE	Yes	No	Pharmacist, Dr, Sc, Ch	Trust, togetherness	Emotion, physical, spiritual	Empathy, Care

377 Jude Eben Taku, "Exploring the 6cs: An Examination of the Evidence and a Personal Reflection," *Research Gate* (August, 2022): 6-7.

S.NO.	Pseudonyms Initials	Age Range	Gender	Referrals	Perceived Level	Qualification	Recognition Level	Valued Level	MDT	Factors MDT	Holistic Care	Qualities of Chaplain
5	LWK	31-40	Female	Low	V poor	Theology/CPE	No	No	Dr, Ch, Sc, Physiotherapist	Communication, together Respect Shared goals:	Take care of wholeness	Confidential Compassion, care
6	BS	41-50	Female	Low	Average	Theology	Sometimes	Yes	N, Sc, Pharmacist, Ch	Trust, communication Clear goals	Spiritual, physical emotional	Compassion, Empathy, Care
8	JE	31-40	Male	Low	sometimes	Theology/CPE	Sometimes	Yes	Dr, N, Ch, Sc, Nutritionist, Pharmacist	Boundaries, respect, Communication	Physical, spiritual, mental	Empathy, Care, Presence
9	GF	21-30	Female	Good	Poor	Theology/CPE	Average	No	Sc, Ch, N, Pharmacist	Solid relationships Communication	Physical, spiritual, mental	Compassion, Care Empathy, Listen
10	CD	31-40	Female	Sometimes	Poor	Theology/CPE	No	No	Dr, Ch, N, Pharmacist Physiotherapist	Communication, trust, Value others	Physical, spiritual, mental	Love, Empathy Care, compassion
11	DB	51-60	Male	Below Standard	Poor	Theology/CPE	No	Maybe	Dr, Ch, Sc, Pharmacist, N	Purpose, Communication Respect, teamwork	Spiritual, physical emotional	Presence, care, compassion Empathy
12	WR	41-40	Female	low	Poor	Theology/CPE	Average	No	N, Sc, Ch, Pharmacist, Mental Nurse	Trust, teamwork communication	Spiritual, physical emotional	Care, Compassion,
13	NE	31-40	Female	low	Good	Theology/CPE	Yes	Yes	Nutritionist, N, Ch, Dr, Pharmacist	Communication Discipline:	Spiritual, physical emotional	Empathy, Love, compassion, Care
14	NM	41-50	Male	Low	Poor	Theology/CPE	No	No	Pharmacist, N, Ch, Sc, Dr, Physiotherapist	Respect, clear goals, Good relationship	Physical, spiritual, mental	Compassion, Care Empathy,
15	FB	21-30	Female	Low	Poor	Theology/CPE	Yes	No	Dr, N, Ch, Sc	Communication, respect	Spiritual, physical emotional	Compassion, Empathy
16	FF	41-40	Female	Low	Poor	Theology/CPE	Yes	No	Dr, N, Ch, Pharmacist,	Togetherness Communication, Discipline:	Physical, spiritual, mental	Care, Compassion, Love
17	JJ	41-50	Female	Average	Poor	Theology/CPE	Yes	No	Ch, Dr, N, Sc,	Communication, value, trust,	Spiritual, physical emotional	Empathy, Compassion Care

S.NO.	Pseudonyms Initials	Age Range	Gender	Referrals	Perceived Level	Qualification	Recognition Level	Valued Level	MDT	Factors MDT	Holistic Care	Qualities of Chaplain
18	AG	51-60	Female	Average	Poor	Theology/CPE	yes	No	Dr, N, Sc, Pharmacist, Ch	Teamwork,	Physical, spiritual, mental	Care, Love, Empathy,
19	AJ	31-40	Male	Low	Poor	Theology/CPE	Yes	No	N, Dr, Sc, Ch, Pharmacist	Communication, trust	Physical, spiritual, mental	Empathy, Care compassion
21	BR	31-50	Female	Low	Poor	Theology/CPE	Yes	No	Pharmacist, Dr, N, Ch, Pharmacist	Respect, Discipline:	Physical, spiritual, mental	Care, Love, Compassion, Empathy
22	GT	50-60	Male	Average	Poor	Theology/CPE	Yes	No	Pharmacist, N, Dr, Ch,	Communication, Trust	Physical, spiritual, mental	Empathy, Love, Care
23	IJ	31-40	Female	Average	Poor	Theology/CPE	Yes	No	Dr, Ch, Pharmacist, Nutritionist, N	Communication,	Physical, spiritual, mental	Compassion, Empathy, Care
24	DE	41-50	Female	Low	Poor	Theology/CPE	Yes	No	Dr, N, Ch, Pharmacist,	Teamwork	Physical, spiritual, mental	Care, Empathy, Compassion
25	CD	41-50	Male	Low	Poor	Theology/CPE	Yes	No	Dr, Ch, N, Pharmacist Nutritionist	Discipline, Shared goals:	Spiritual, physical	Compassion, Empathy, Care.

6.4 Challenges of Chaplains

From figure 6.1, nineteen chaplains said low remuneration was a challenge. Some chaplains said their pay package unveiled the kind of value that was placed on them. Some respondent mentioned that they were devalued, relegated to the background. This affected their emotional being. Six interviewed chaplains spoke of the working space that made them that excluded in their own house. A chaplain commented that in majority of the CBC hospitals, the chaplain's office curved out which was an indication that the chaplaincy departments was not included in the original plan of the construction of the CBC hospitals.

Cadge sates that in carrying spiritual assessment, some hospitals that faced constricted health care budgets chose to redundant chaplains first because their role was not valued.[378] Jeffries suggested that may be the redundancy of chaplains could have been because their work could not be measured as those of nurses. Cadge comments that who those who are skilled at mediating between patients and hospital staff-often have no one they can rely on to advocate for them at budget time before the administration.[379]

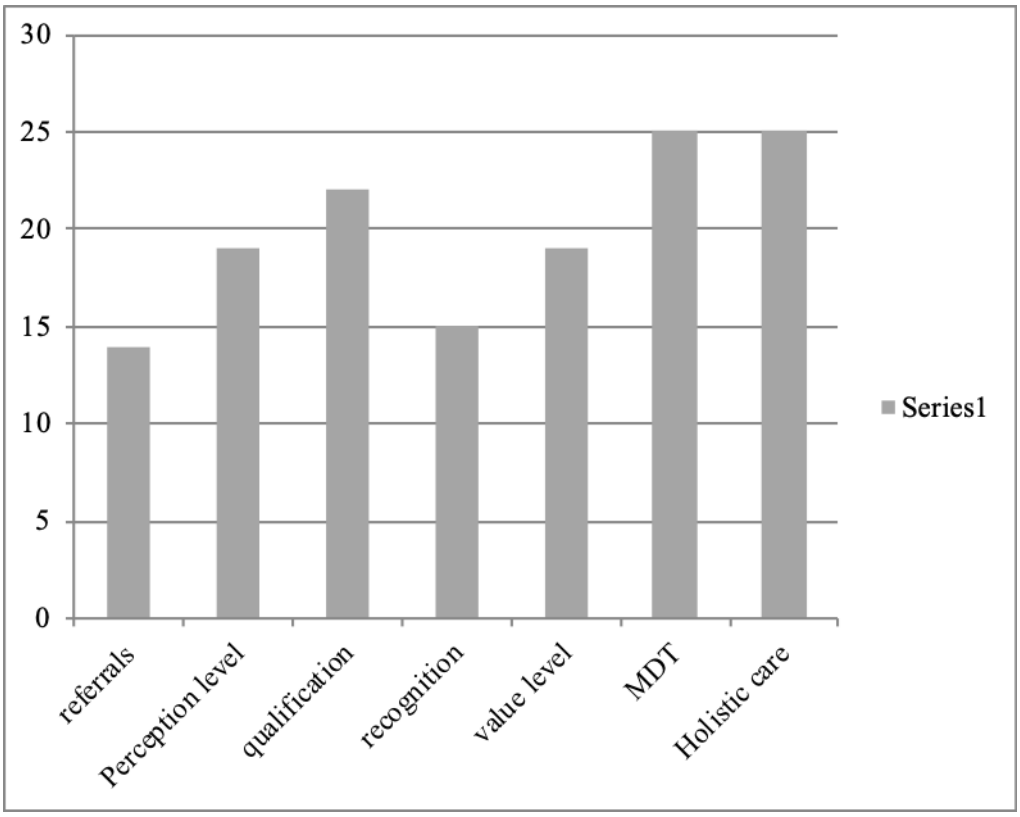


FIGURE 1. RESPONSES OF THE INTERVIEWERS

6.5 Conclusion

[378] Cadge, *Lost in Translation, 50-60.*

This section summarized the key themes that surfaced from the interviews that the researcher conducted. The themes gave the researcher a more precise picture, and insight about the perception of the role of hospital chaplains in the multidisciplinary team at the Cameroon Baptist Convention. The themes that emerged were my primary sources which the researcher did a comparative study of the primary study with the secondary sources which featured in the literature review. This comparison gave me an insight into how other researchers have approached my topic, what the challenges are and how to overcome them.

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[379] Cadge, *Lost in Translation,* 23-25.

CHAPTER 7

SUMMARY, IMPLICATIONS, RECOMMENDATION, AND CONCLUSION

7.1 Introduction

The purpose of this phenomenological study was to explore thoroughly the lived experiences and the perception of the hospital chaplain in the MDT in the CBC. This chapter contains the summary, recommendations for future research, ministry application, and conclusions based on the results obtained in the Study.

7.2 Summary of the Findings

The phenomenological study made use of the semi-structured protocol with a list of questions specific to the research topic. Through this method, the data that was needed was obtained. A variety of methods were used to conduct the interviews, data collection, and data analysis. Interviews were conducted through Phone calls, WhatsApp video calls, and zoom were used. The study revealed factors that hindered a healthy MDT approach. It also investigated the themes that emerged from the data collection and data analysis.

7.3 Implications

The study provided lessons for the MDT, Chaplains, and hospitals Administration. These lessons are briefly discussed as follows.

7.3.1 The Multidisciplinary Team (MDT)

1. When members of the MDT could work towards a MDT team approach, which is more inclusive and respecting boundaries as they discharged their functions. The MDT is a therapeutic team whose primary task is the cure and health of the patient. Working from a holistic approach where all members are recognized, and their roles fully used will bring quality care to patients.

2. The MDT could work towards creating awareness through sensitization, educative forums, sor seminars about the importance of the integration of chaplains in the health care teams for quality care. The integration of chaplain on the team is clarified through, will help highlight.

3. The MDT could maximize team dynamics which will help foster healthy MDT were generated from the data which are solid relationships, healthy communication, and respect for each other's role, clear roles, and purpose. They could make use of team dynamics dysfunctional factors which are conflict, lack of trust, hindering the integration of chaplains, likewise factors enhancing it as a check guide.

7.3.2. Lessons to Chaplains

A. Working Relationship. The strategic and fundamental element of the chaplain's "success" is that of an ongoing working relationship with all the staff members of the hospital be cultivated. The medical staff needs education and exposure to the functioning of the chaplain, and this can only come about through creating a conducive atmosphere which is non-threatening for all. The chaplain could take the lead in building relationships.

B. The chaplains of the CBC hospitals should recognize that they have unique calling. This unique calling challenges chaplains them to bear witness to Jesus' compassionate ministry to the sick and suffering, care for the spiritual needs of people,

and be with the voices of suffering inside the corridors of hospitals be it secular or faith-based institutions.

C. Chaplains should create awareness and seek educational platforms where they can talk about their role to MDT. A chaplain's role on the team may vary and lack clarity, which increases levels of poor perception. Due to the poor understanding of their role coupled with lack of value placed on their work, they are more vulnerable to marginalization, ignored and relegated which will affect them.

D. The study further revealed that the poor perception was due to ignorance. Therefore, the need to emphasize sensitization, continuous education, effective communication skills, and in-service seminars on team dynamics will be a good strategy to clarify misconceptions around their role.

E. Hospital chaplain should have a theological background, and a CPE unit when applying for a chaplaincy job in the CBC hospitals. Chaplain should understand why it is important to study and do pastoral care and CPE before becoming a chaplain. CPE units are needed to help chaplains understand their relationship to hospital ministry. CPE will assist the chaplain to gain awareness and understanding on how to do self-evaluation, self-reflection and integrate spiritual and theological insights into their pastoral care.

F. The presence of the chaplain during ward reports and handing over are crucial for their ministry because it will give the chaplain an understanding of which patients need pastoral care as the nurses read their report. When the chaplains are actively involved in the MDT ward report, they will build solid and meaningful relationships with staff. If the chaplains' involvement is felt in the daily routine of the team, the team will utilize the chaplain fully.

G. Chaplains are encouraged to move from their offices into the wards and take the initiative to do pastoral care without necessarily waiting for referrals since those referrals do not come as expected. These are initiative-taking steps into ministry.

7.3.3 Lessons to the Administration

1). The administration should intentionally advocate, affirm, and accept that spiritual care is an essential component of holistic care. This can be done by reinforcing and voice on their role. When their voice is added to that of the chaplains, there will be a positive response. When it's just the chaplains, they become frustrated and discouraged.

2). Educational opportunities could be used to address the needs of staff members regarding the ministry of the chaplain through workshops, seminars, or talks.

3). The certificates of the chaplains are not inferior to those of the nurses. It is all about experts from different fields coming together for the good of the patients. Their certificates should be given equal value as those of the nursing core.

7.4 RECOMMENDATIONS

Throughout the research work, the sample participants were chaplains. There could be a possibility of being biased. A Study including other members of the MDT and administration as part of the sample size could give a balance approach to the role of a chaplain.

7.5 Ministerial and Personal Application

The healing ministry is a vital component of a healthy church. Jesus was a wholistic healer. As followers of Jesus Christ, He remains our example, and our theological model in conducting the great commission. Therefore, the church can partner with chaplains as they conduct this calling into the health ministries by praying for the sick and the chaplains in their congregations, by supporting the chaplains financially and to make regular visitation to the hospital to encourage and pray for the sick ones.

The participants who participated in this research answered the call of God into the healing ministries. The researcher has been part of the healing ministries and drawing

inspiration from this verse in the Bible. When Jesus saw the crowd, He had compassion for them because they were confused, helpless, and were like sheep without a shepherd (Matthew 9:36). This verse function as a tool for the researcher to follow and integrate theological reflections into pastoral care as she ministers to patients, families, and staff nonjudgmentally. A nonjudgmental approach in which every patient can be listened to, comforted, cared for in the hospital and without discrimination. If pastoral care given to patients should have make meaning in their lives, it should find its roots in the person and works of Jesus Christ Healing is central to the ministry of Jesus.

7.6 Conclusion

The research questions investigated the perception of the role of the hospital chaplains in the MDT in the Cameroon Baptist Convention. The data was collected from interviews, and questionnaires that were sent to the twenty-five chaplains. The phenomenological method investigated the lived experiences of the chaplains. The researcher was able to see from the data that the participants acknowledged the fact that the hospital recognized them as chaplains, but the confusion came from their role in the team and how they were used making, them not valued, and unimportant. This explains why the recommendations made after the findings were addressed to MDT, chaplains, and the administration. Communication, educative seminars, and awareness could be helpful tools in bridging the gap. The participants stated that ignorance could have contributed to some of the misconceptions about chaplains as some MDT members came from different religious backgrounds. From the research findings, the chaplains were honest with the responses and the factors that made them not to be fully utilized.

APPENDIX

THE RESEARCH QUESTIONS

Dissertation Title; The Perception of the Role of the Hospital Chaplain in the Multidisciplinary Team in the Cameroon Baptist Convention

1. Age range: [below30] [31-40] [41-50] [Over 50]
2. Gender: [Male] [female]
3. What are some key qualities a chaplain should have? Name four!
4. Name some perceived roles of hospital chaplain?
5. Is the role of the chaplain recognized?
6. in the hospital. If yes How? If not, what is limiting him?
7. What traits do you look for in a chaplain? Name four words that qualifies a hospital chaplain.
8. What is CPE (Clinical Pastoral Education)?
9. Why would you recommend CPE for hospital chaplains?
10. What is a Multidisciplinary Team in the hospital and who are the members of the team?
11. Are chaplains involved in MDT meetings and used, or valued as they should? a) Yes, b) No, c) sometimes. Explain.
12. What is the perception level of the chaplain in the multidisciplinary team? (Poor),

(Good) (Best)? Briefly state why?

13. Do chaplains feel respected and treated fairly in the MDT? A) Yes, b) No, c) partially. Explain

14. What factors make an effective Multidisciplinary team? Name five of them**.**

15. What are the factors of a dysfunctional Multidisciplinary Team?

16. Is the chaplain represented in the different committees, (Ethics, Management, Discipline, Exco Meetings? a) Yes b) No, Is his voice heard? How? What impact does he make in the committee?

17. How often do members of the Multidisciplinary Team refer clients /patients to the chaplain? (More often), (Less Often), (Not at All**),** why? Suggest some possible reasons**.**

18. What is holistic care in a hospital and why should a chaplain be part of it in a patient's life. Name those components of holistic care.

19. Do all MDT members know the chaplain's role on the team? If yes, How, if no why explain.

20. Do team members identify and refer cases to the chaplain? If yes how (verbal or written explain), if not, what should be contributing to lack of referrals or timid referrals?

21. What are some ways the chaplain has intentionally made their role known?

22. What are some challenges that hospital chaplains face?

23. Has there been times that the absence of the chaplain on the team affected work? If yes how and if no, why not?

24. What types of seminars and training have you received about multidisciplinary teams?

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